Maternal and Child Health Services
Title V Block Grant

State Narrative for Delaware

Application for 2011
Annual Report for 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certification Forms are kept on file in the State MCH program's office and can be made available by request to Alisa Olshefsky, M.P.H, Director of Maternal and Child Health or Leah Jones, MCH Deputy Director. The State MCH Program Office is located at 417 Federal Street, Jesse Cooper Building, Dover, DE 19901 (The State Public Health Administration Building).

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

The MCH Bureau initiated a series of intimate in-person "listening sessions" or "coffee klatches" all across Delaware in early April 2010 targeting families of CYSHCN. Sessions lasting 1.5 hours were set for seven sites across all three Delaware counties at well known and easily accessible State Service Centers. A Spanish language interpreter was available. Sign language interpretation was available on request. Both English and Spanish language flyers were disseminated across various partner and contractor email lists and listservs and websites. Turnout was not as high as hoped. However this was the first year of the strategy, the MCH program is confident that this strategy should be institutionalized and become a part of regular outreach to families of CYSHCN.

In April 2010, the Family Support Initiative (FSI), in partnership with MCH, held a partner meeting with CYSHCN-serving organizations and parent-led groups. During the meeting, the Title V needs assessment was discussed and participants were asked to share an executive summary and brief survey with all the parents and families they represent or connect with on a daily basis. Families could select to provide survey feedback via email, web survey, or hard copy through a self-address stamped envelope. Families were asked to respond to three core questions in addition to free form comments:

• If you could give advice to service providers about how they can improve family/individual involvement in decision-making, what would you say?

• Do you feel that our performance measures are on track as it relates to those who support families with special health care needs?

• Is there anything else you would like to tell us that would help us understand how families of children with special health care needs can be served better in Delaware?

Family feedback was incorporated into the final version of the state priorities around CYSHCN. The support of community organizations involved in FSI was essential to wide spread dissemination of the survey. They endorsed the process and shared the information with families they serve.

In May 2010, the MCH program presented to the Delaware Healthy Mother & Infant Consortium regarding the needs assessment. Similar to the CYSHCN forum, DHMIC members were provided an executive summary and asked to complete three questions about the proposed state priorities. The DHMIC was an ideal forum for feedback since the coalition is composed of over eighty organizations serving women, families, infants and youth. Feedback was provided via email and web-based survey.

In the web-based survey, parents were asked what advice they would give to providers and whether the performance measures for CSHCN were "on track." Parents (n=5) responded that providers should make more information available to families, ask families directly for their feedback, respect the input of families and eliminate bureaucratic barriers in the referral process. Parents thought that generally, the performance measures were on track in measuring their concerns, however there was some sentiment that the performance measures were vague in terms of measuring effectiveness.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The Delaware Maternal and Child Health (MCH) program began working on the Five Year Needs Assessment early in 2008. The intent was to review, assess, and re-vamp the MCH Block Grant-related activities and programs to ensure the state performance measures were not duplicative of national measures and that they truly reflected state priorities. Moreover, it was determined that the 2010 Needs Assessment should serve as a living document to guide and serve as a metric for MCH programs and services. In summer 2008, an internal workgroup was established and trained on the Capacity Assessment for State Title V process (CAST-5). In September 2008, the MCH Needs Assessment Workgroup was formally established (SECTION II). This workgroup included the internal Division of Public Health (DPH) workgroup along with families, advocates, clinicians, and organizations serving children and youth with special health care needs (CYSHCN). A total of 35 individuals from across the State of Delaware participated in the needs assessment process.

After the workgroup was formed, tools and strategies were used to help identify state priorities. Over the course of seven months, the MCH Needs Assessment Workgroup established criteria, including weighting and ranking parameters for 33 varied health conditions affecting the MCH population groups. By using a dual approach of individual and group ranking of health conditions, workgroup members could be engaged on each condition while still focusing on those that most impacted/interested them. The capacity of Delaware's current MCH-related programs to meet the needs of persons affected by these health conditions was also determined using the MCH Pyramid of Health Services conceptual framework.

Ten state health priorities emerged from the MCH Needs Assessment process. Delaware's 2010 MCH priorities include:

1. Infant Mortality. Decrease infant mortality and eliminate the disparity in infant mortality among Black women.
2. Low Birth Weight/Preterm Births. Decrease low birth weight (= 2500 g) and very low birth weight (= 1500 g) births and births occurring between 32 and 36 weeks gestation.
3. Obesity and Overweight Among Children & Teens. Decrease obesity and overweight among children and youth between the ages of 6 and 19.
4. Obesity Among Women of Childbearing Age. Decrease obesity among women of childbearing age - between the ages of 15 and 44.
5. Unintentional Injury Among Infants, Children & Teens. Decrease unintentional injuries and deaths due to unintentional injuries among children and youth between birth and age 21.
6. Teen Smoking. Decrease tobacco use among adolescents.
7. Family Support for Children and Youth with Special Health Care Needs. Increase effectiveness and efficiency of organizations that serve families of children with special health care needs.
8. Developmental Delay. Increase the percentage of children who are either at low- or no- risk of developmental, behavioral or social delays.
9. Disparities Among Families of Children and Youth with Special Health Care Needs. Decrease disparities in child health, emotional/mental health, health care access/quality and family health indicators among children and youth with special health care needs.
10. Child Oral Health. Decrease the percentage of children with untreated caries and eliminate the disparity in untreated caries among Black children.

The Delaware 2010 Needs Assessment represents the first step in a cycle of continuous improvement of maternal, child, and adolescent health. Between 2010 and 2015, actions and strategies will be implemented, results will be monitored and evaluated under the State Performance Measures included in this application, and supplementary data, and necessary adjustments will be made in an effort to enhance the health of women, children, and adolescents in Delaware.

The complete 2011-2015 Needs Assessment Report is attached.

III. State Overview

A. Overview

Title V Agency Overview

The Delaware Department of Health and Social Services (DHSS) consists of 12 distinct divisions and the Delaware Health Care Commission with an overarching mission to improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations. The Delaware Division of Public Health (DPH), the largest division within DHSS, is the Title V agency responsible for planning, program development, administration and evaluation of maternal and child health (MCH) programs statewide. DPH is led by Karyl Rattay, MD, MS, FAAP, FACPM who serves as the Division Director. Within DPH, the Family Health and Systems Management (FHSM) section has direct oversight of Title V, as well as a number of other MCH programs including the Children with Special Health Care Needs (CSHCN), the Early Childhood Comprehensive Systems (ECCS) Program, the Newborn Metabolic Screening Program, the Newborn Hearing Screening Program, the Birth Defects Registry, the Autism Registry, the State Systems Development Initiative, the Adolescent Health Program, the Infant Mortality Elimination Program, the Center for Family Health Research and Epidemiology, the Title X Family Planning Program and the Health Systems Management Bureau (including program management of rural health, Federally Qualified Health Centers [FQHCs], and the Conrad State 30/J-1 Visa Program - a recruitment program for physicians).

FHSM is managed by a Section Chief, Alisa Olshefsky, MPH, who also serves as the state's Maternal and Child Health Director. FHSM is structured into four Bureaus: The Maternal & Child Health Bureau (which directly administers Title V), the Adolescent & Reproductive Health Bureau, the Center for Family Health Research and Epidemiology and the Bureau of Health Resources Management.

In addition to programmatic efforts under FHSM, the Title V MCH Block Grant Program funds staff positions in community public health clinics for four key programs. These programs are Smart Start, Kids Kare, Child Development Watch (CDW), and the State's Oral Health Program. Field staff is under the direction of the State's Medical Director, Herman Ellis, M.D. Smart Start is a prenatal program addressing women at-risk for poor birth outcomes. Kids Kare is a case management program focusing on child health for children and adolescents from birth through 21 years of age. Currently, these two programs (Smart Start/Kids Kare) are being integrated to complement the State's overall efforts around building a comprehensive "evidence-based" home visiting program under the Healthy Families America model. As part of a comparative analysis led by the Delaware Maternal & Child Health Bureau during 2010, an assessment was completed of DPH home visiting services. The MCH program provided leadership on a project to assess the applicability of evidence-based home visitation. In collaboration with other community-based MCH organizations, the state will implement an integrated and comprehensive home visiting program where families are referred to different programs through a centralized intake (e.g. Nurse-Home Visiting, Healthy Families America and Parents as Teachers) depending on needs and eligibility. CDW is a program dedicated to screening, case management and referral for CSHCN from birth through 3 years of age and their families. The Oral Health Program provides preventive dental services to children. In addition to Title V funds, state general funds and appropriated special funds (fees, revenue, for example) also support staff in these programs.

Each of the programs within FHSM is integrated with a common mission and strategic objectives. The mission of the FHSM section is to improve the health of families and provide leadership to communities in the development of health systems. FHSM accomplishes its mission by:
• developing, coordinating and evaluating programs and initiatives to improve the health of women, infants, children, adolescents and those with special health care needs;
• monitoring health status through newborn screening (metabolic disorders and hearing), birth defects and autism registries;

• eliminating disparities in maternal and child health outcomes, including infant mortality;
• ensuring access to adolescent health care services through School-Based Health Centers (SBHCs) and implementing programs to reduce teen pregnancy;
• applying epidemiology and research to improve delivery of quality health care to women, children and families;
• enhancing reproductive health and ensuring access to family planning services;
• translating evidence into practice to improve early childhood comprehensive systems of care; and
• ensuring health systems across the state have the ability to meet Delawareans' health care needs by focusing on primary care, rural health, identifying and addressing health care provider shortages, and helping to improve access to data and health information.

FHSM's programs address the following areas.

• The Children with Special Health Care Needs program works closely with Child Development Watch, the state's birth to three program, and other organizations throughout the State to coordinate services and address key issues including transition to adult services, family involvement and capacity building. In the past year, a major addition to the CSHCN program has been the implementation of a Family Support Organization, through the University of Delaware's Center for Disabilities Studies, to provide coordination and other support among the state's assorted organizations and groups that serve families with Children with Special Health Care Needs.
• The ECCS Program partners with organizations throughout the state to plan, to develop and to implement partnerships to support child development and ensure that all Delaware's children are healthy and are ready to learn at school entry.
• The Newborn Metabolic Screening Program and Newborn Hearing Screening Program screen newborns for metabolic conditions and hearing deficiencies, as well as maintain the state's Birth Defects and Autism registries.
• The State Systems Development Initiative works with Title V in building capacity for data analysis and the linking of MCH datasets. SSDI also is a key participant in the MCH needs assessment process and works closely with the Center for Family Health Research and Epidemiology on pilot studies.
• The Infant Mortality Elimination Program funds contractual programs for at-risk pregnant women and preconception programs for women (Healthy Women, Healthy Babies. The Infant Mortality Elimination Program's initiatives also include a research component (including the Pregnancy Risk Assessment Monitoring Surveillance survey) carried out through the Center for Family Health Research and Epidemiology and the State's Fetal Infant Mortality Review (FIMR) Program (through the Administrative Office of the Courts).
• Title X, the federal Family Planning Program, works closely with Title V on a wide range of issues including teen pregnancy prevention, preconception care and women's health issues.
• School-Based Wellness Centers are located in high schools statewide and provide preventive services to students.
• Teen Pregnancy Prevention programs (Wise Guys and Making Proud Choices) are offered throughout the state to reduce the risks of STDs and the incidence of teen pregnancy.

Title V related activities throughout FHSM and DPH support the stated section mission across each of the four levels of the MCH pyramid (direct services, enabling services, population-based services and infrastructure building activities) as detailed further throughout this application. The next section broadly describes the current system contexts, including some of the principal characteristics of the state's maternal and child health populations.

Population Characteristics

Delaware is a small mid-Atlantic state located on the eastern seaboard of the United States. Geographically, the state's area encompasses only 1,983 square miles ranking Delaware 49th in size among all states. Delaware is bordered by the states of New Jersey, Pennsylvania and

Maryland, as well as the Delaware River, Delaware Bay and Atlantic Ocean. Centrally located between four major cities, Wilmington, the state's largest urban center is within an hour's drive to Baltimore, MD and Philadelphia, PA and within two hours driving distance from New York City and Washington, D.C.

According to the latest population estimates, in 2010 the State of Delaware had about 896,880 residents, of which 75% were Caucasian and 21% were African-American. The Hispanic population in Delaware has been increasing over the past decade. The latest estimates that are available regarding Hispanics are from 2007. In 2007, it was estimated that 6.5% of Delawareans were Hispanic. This is an increase of about 250% over the 2002 Hispanic population (estimated to be about 2.4% in 2002). According to the U.S. Census, in 2007, there were about 55,200 Hispanics in Delaware.

Of Delaware's three counties, New Castle County, in the northern third of the state, is the largest in population with about 539,590 residents or about 60% of the state's total population. New Castle County also has a large population of African-American residents (about 24%) and within the city of Wilmington, the state's largest concentration of African-American residents (about 55 percent of the city's population). New Castle County also has the largest proportion of Hispanics. Kent County and Sussex County, located in the southern two-thirds of the state, are more rural than New Castle County. In 2010, the estimated population of Kent County was about 159,980 residents (75% Caucasian and 23% African-American). For Sussex County, which includes very rural areas as well as coastal resort towns, the 2010 population was about 197,310 (85% Caucasian). Since 2000, the State's population has increased by about 14.0 percent.

In 2010, statewide, it is estimated that there are about 172,250 women of childbearing age (15-44 years of age) and 253,000 infants, children and adolescents aged 0-21 years of age. Annually in the state, about 13,000 infants are born.

Economic Indicators

In Delaware, from 2007-2009, it is estimated that 13.1% of children, aged 0-17, were living in poverty, with the highest rates among those children aged 0-5 (17.4%). Children in Kent and Sussex County are slightly more like likely to live in poverty than children in New Castle County (14.6% vs. 12.2%). During the same time period, 19.6% of Delaware's children lived in a household with underemployed parents (where no parent worked full-time, year round). Over one-quarter (26.7%) of children from single parent households in Delaware lived in poverty compared to 6.9% of children living in two parent households. The median income of two parent households in Delaware from 2007-2009 was $75,210 compared to $26,103 for single parent households and $23,735 for female-headed households. Of Delaware's children, 31.8% lived in a one-parent household in the 2007-2009 time period. Almost half (46.5%) of births occurring in the five year period 2003-2007 were to single mothers with 71.4% of African American births occurring among single mothers compared to 39.2% of Caucasian births occurring among single mothers (Kids Count in Delaware, 2010). It is estimated that 13% of Delawareans below the age of 65 are without health insurance. As of August 2009, 53,078 adults and 50,998 children received food assistance through Delaware's Supplemental Nutrition Assistance Program (SNAP) and 2,792 adults and 8,930 children received cash assistance through the Temporary Assistance to Needy Families Program (TANF) (KIDS Count in Delaware, 2010).

As with much of the nation, the current overall economy in Delaware is the worst since the mid-1970's. As of April 2010, Delaware's seasonally adjusted unemployment rate was 9.0% (compared to 9.9% nationally) (Delaware Department of Labor, May, 2010). Over recent years, the greatest job losses have occurred in construction, manufacturing, administrative and waste services and retail trade (Delaware Department of Labor, 2008). Currently, Delaware's largest employment sector is Trade, Transportation and Utilities (18% of the non-farm workforce), followed closely by government (15%) and professional and business services (13%) (Delaware Department of Labor, May, 2010).

Geographic Health Disparities

Although the state is relatively small, disparities exist between the state's three counties as well as between rural and urban areas of the state with regard to healthcare access and utilization.

Many of the state's geographic service areas are federally designated shortage areas. Various geographic service areas in New Castle County are designated as primary care, dental, and mental health professional shortage areas (HPSAs). Three geographic service areas in New Castle County are designated as a Medically Underserved Area (MUA). All of Kent County is designated as a low-income primary care HPSA and a low-income dental HPSA. As well, all of Kent County is designated as a low-income medically underserved population. All of Sussex County is designated as a low-income primary care HPSA and as a dental HPSA. As well, all of Sussex County is designated as a low-income medically underserved area. In 2007, two geographical areas were designated as mental health professional shortage areas in the state (spanning areas in each of the three counties). Southern New Castle County and Northern Kent County are designated as well as much of Sussex County (aside from the eastern seaboard). Overall, fifty-one percent of Delawareans reside in a federally designated Primary Care Health Professional Shortage Area (HPSA); forty-five percent reside in a dental HPSA; and twenty-one percent reside in a mental health HPSA.

Statewide, the percentage of women accessing prenatal care in the first trimester was higher than the national average for the five year period 2001-2005 (87.4% for Delaware vs. 72.7% for the United States). In the most recent available two five year periods (2002-2006 and 2003-2007) however, the statewide percent of women accessing prenatal care in the first trimester has been declining (82% and 78%, respectively). This decline has been reported in each of the state's three counties, as well as the city of Wilmington. In the 2003-2007 reporting period, Sussex County was lowest in terms of pregnant women accessing prenatal care in early pregnancy (63.4% vs. 71.5% for Kent County. 84.5% for New Castle County and 77.9% for the City of Wilmington). It is important to note that these data were reported prior to full scale operation of the State's current Infant Mortality indicatives (Healthy Women, Health Babies).

From 2003-2007, in terms of birth outcomes, Wilmington is the geographic area with the highest percentages of low birth weights (13.6% compared to 9.3% statewide) and very low birth weights (2.9% compared to 1.9% statewide).

From 2003-2007, New Castle County had a higher infant mortality rate than the state as a whole (9.2 infant deaths per 1,000 live births compared to 8.5 infant deaths per 1,000 statewide). However, the driving force in New Castle County infant mortality is within the City of Wilmington (12.7 infant deaths per 1,000 compared to 8.4 infant deaths per 1,000 in the balance of the county).

The City of Wilmington and Sussex County have the highest teen birth rates (87.0 and 58.6 births per 1,000 females aged 15-19) over the five year period 2003-2007. Statewide, the teen birth rate during this period was 43.0 (compared to 41.6 births per 1,000 females nationally). In the state in general, the teen birth rate among black teens exceeds the teen birth rate among white teens (67.4 vs. 35.0 births per 1,000 females aged 15-19). In the City of Wilmington, however, the teen birth rates are comparable among both black and white teens (91.5 vs. 94.8 live births per 1,000 females aged 15-19, respectively).

Among 11th grade students, Sussex County has the highest rates of youth tobacco, alcohol and substance use. In 2008, 19% of Sussex County's 11th Grade students smoked cigarettes (compared to 15% statewide), 44% drank alcohol (compared to 41% statewide) and 23% smoked marijuana (compared to 22% statewide).

According to the 2000 U.S. Census, Kent County is the county with the highest risk of poverty

ratio (2.5, comparing female headed households to male householder families). However, both Kent and Sussex Counties exceed the statewide percent of female headed household families living in poverty (30.2% and 31.1%, respectively, compared to 26.3% statewide).

The City of Wilmington, similar to many urban areas throughout the nation, has correspondingly high rates of social risks and poor health outcomes such as juvenile arrests, high school drop-outs, HIV/AIDS (with a high proportion attributable to needle sharing) and sexually transmitted infections.

Racial/Ethnic Disparities

In 2008, the Office of Minority Health released the Delaware Racial and Ethnic Disparities Health Status Report Card. This report highlighted many problematic indicators of health disparities between African-Americans, Hispanics and Caucasians (the reference group) using a "disparity ratio" as the indicator. The African-American Infant Mortality rate from 2001-2005 was found to be 2.5 times that of Caucasians (17.1 vs. 6.8 per 1,000 live births). For the same time period, the percent of Hispanics with late or no prenatal care was 2.7 times that of Caucasians (9.1 vs. 3.4). The rate of diabetes among African Americans in Delaware from 2001-2005 was 2.2 times that of Caucasians (49.2 vs. 22.5 per 100,000 population). For the same time period the adjusted HIV mortality rate among African Americans was 14.5 times that of Caucasians. The report also noted that among Hispanics, the birth rate to teenage mothers was 3.8 times higher than Caucasians from 2001-2005 (131.4 vs. 34.4 per 1,000 females, age 15-19).

Children and Youth with Special Health Care Needs (CYSHCN)

In 2006, 908 children ages 0-3 years received early intervention services in accordance with Part C in Delaware. Of these children, 59% were White non-Hispanic, 28% were Black non-Hispanic, 11% were Hispanic, 2% were Asian or Pacific Islander, and 0.1% were American Indian or Alaska Native. Children ages 2-3 years accounted for 55% of the children receiving services while 32% were ages 1-2 years and 12% were birth to 1 year of age. Finally, 62% of the children receiving services were female and 38% were male.

Based on rates from the 2005-2006 National Survey of Children with Special Health Care Needs, of families of children to age 18, it is estimated that about 34,500 Delaware children (17.5%) younger than age 18 years may have a special health care need. Around 7,000 (20.4%) of Delaware's CSHCN have health conditions that consistently and often greatly affect their daily activities. Rates were somewhat higher for Black children (22.5%) compared to 17.9% for Caucasian children. Rates were also far higher for families with incomes less than 100% of the federal poverty level (FPL) (32%) and for those between 100% and 200%, (30.5%) compared to 12%-18% for other income groups. As seen in the table below, Delaware had higher prevalence of CSHCN, a greater percentage of households that have at least one child with special healthcare needs; and a higher rate of CSHCN in every age and racial category and gender, than the national average.

Table 1: Select Delaware Data from the National Survey of Children with Special Health Care Needs, 2005/2006
Prevalence Statistics

	State %	Nation %
Percentage of Children & Youth with Special Health Care Needs, 0 - 17 yrs old	17.5	13.9
Prevalence by Age:		
Children 0-5 years of age	10.4	8.8
Children 6-11 years of age	21.8	16.0
Children 12-17 years of age	20.5	16.8

Prevalence by Sex:						
Female					13.3	
	11.6					
Male			21.5		16.1	
Prevalence by Poverty Level:						
0% - 99% FPL		17.6		14.0		
100% - 199% FPL			16.5			
	14.0					
200% - 399% FPL			17.6			
	13.5					
400% FPL or greater	17.9	14.0				
Prevalence by Race/Ethnicity:						
Hispanic				9.2		
8.3						
White (non-Hispanic)	19.6	15.5				
Black (non-Hispanic)	16.0	15.0				
Multi-racial (non-Hispanic)			17.0	17.9		
Asian (non-Hispanic)	....	6.3				
Native American/Alaskan Native (non-Hispanic)			....	14.5		
Native Hawaiian/Pacific Islander (non-Hispanic)			....	11.5		

The National Survey of Children with Special Health Care Needs Survey data suggest that in 2005 about 4,900 (14.2%) of Delaware's CSHCN younger than age 18 years had one or more unmet needs for specific health care services. Rates were higher for Black (27.7%) and Hispanic children (33.2%), compared to 11.7% for Caucasian children. Close to half of children living in families less than 100% FPL had unmet needs, 19.4% for those 100% to 200%, and 12.7% 200% to 400%. Those families with private insurance were half as likely to report unmet needs (9.8%), compared to those with public insurance (17.9%). It is unclear from the data what the unmet needs of these populations are specifically.

The Survey data also indicate that 29.7% of all Delaware CSHCN are without family-centered care. More than 50% of Hispanic (53.8%) and 47.5% Black CSHCN are without family centered care, compared to 27.1% for Caucasian. About half of CSHCN living in families below 200% did not have family-centered care, compared to fewer than 30% at higher income levels. Family centered-care is a philosophy that incorporates the family as an integral component of the health care system. These data on unmet needs, lack of family-centered care, and lack of a medical home indicates the disparate needs of Black and Hispanic families and low-income families.

According to the 2005-2006 National Survey of Children with Special Health Care Needs, 57.6% of families with CSHCN do not receive the services necessary to make the appropriate transition to adult health care, work and independence. In 2007, the University of Delaware's Center for Disabilities Studies completed a survey project focusing on CSHCN transition to adult services. The survey focused on three main research questions: 1) Do young adults who leave pediatric medical care at A.I. duPont Hospital (Delaware's only children's hospital), have primary and specialized adult medical care to address they typical and specialized chronic health care needs? 2) To which types of adult health care services do young adults have access after they transition from A.I. duPont. 3) How satisfied are these young adults and their families with the care they receive in the community?

The survey found that while the majority of young adults report access to specialist care, many of these young adults did not have a specialist. Despite this perceived access, one-half of respondents did not have a specialist. Moreover, among those without a specialist, 39% reported they do not know the type of specialist they need. A large majority of the respondents was very satisfied with their adult primary care provider, but about half expressed encountering difficulty in

the process of transitioning to adult services.

The findings of this study supports the NSCSHCN data that adult transitions are problematic for many youth. The process of transition was reported as difficult by about 50% of study participants. They also reported child health services much easier to navigate than adult health services. In addition, participants reported many services available in the child system were not available in the adult system (e.g., daily care support).

Current Priorities and Initiatives

The Family Health and Systems Management (FHSM) is currently working on a number of initiatives focused on improving Maternal and Child Health. The MCH Bureau is working with the University of Delaware to implement a statewide survey of families with children and youth with special health needs. The survey will be based on items from the National Survey of Children with Special Health Care Needs. The survey's results will provide evaluative data of our current efforts in enhancing supports for families with CYSHCN through the family support initiative. The Newborn Metabolic Screening and Newborn Hearing Screening Programs are working to create a data system and processes for follow-up. This follow-up will include the capacity to follow-up on interventions for birth defects, late onset hearing loss and possibly some metabolic disorders. Related to this system enhancement is an effort to increase reporting to the state's Autism registry. Reporting of autism and autism spectrum disorders is required by Delaware statute; however the system is currently underutilized. As the Healthy Women, Healthy Babies program completes its first full year, FHSM, through the Infant Mortality Elimination Program and the Center for Family Health Research and Epidemiology will measure and evaluate the behavior change that results from the array of interventions offered through this program, as well as health outcomes that may be captured. The Infant Mortality Elimination program is also launching a statewide preconception care social marketing campaign that includes promotion of a reproductive life plan.

A new initiative closely related to one of Delaware's State Performance Measures (decreasing the proportion of children at risk of developmental delays in early childhood) resides within the Early Childhood Comprehensive Systems (ECCS) program. In the proposed program, a child care health consultant (CCHC) will be a licensed or certified health professional (e.g. nurse, nurse practitioner, physician, health educator, oral health professional, and nutritionist) specifically trained to work with child care providers. Families depend upon child care businesses to meet their children's needs, anticipate problems and concerns, and to direct or refer families to needed resources. Other best practice state models use nurses, solely, to fill the role of the CCHC (e.g. Iowa and Illinois). As such, Delaware is proposing the Child Care Nurse Consultant (CCNC) program to provide the missing link and credibility for needed health, safety, and positive development in early care and education programs.

As a result of the 2010 Needs Assessment, and as described in greater detail in the 2010 Needs Assessment report, Delaware has identified 10 priorities specifically related to the Title V MCH Block Grant Program. These priorities are:

Reduce Infant Mortality. Infant Mortality is a top priority in Delaware since the Infant Mortality Rate (IMR) is consistency higher than the U.S. average. In 2005, the Governor convened an Infant Mortality Task Force (IMTF) to make recommendations for reducing infant deaths in Delaware. The task force put together list of 20 recommendations. The task force developed into the Delaware Healthy Mother and Infant Consortium (DHMIC). The Consortium united with the DPH to establish infant mortality programs. Of the 20 recommendations, half were implemented over the following three years including targeted services for women during the preconception, prenatal, and postpartum periods. Additionally, research to explore the causes of infant mortality was undertaken through surveys and implementation of state surveillance systems. Through the combined effort of DHMIC and the DPH and support from the Governor's office and the Delaware Legislature, the DHMIC prenatal programs reached about 15% of all Delaware pregnancies in

2009. Furthermore, Delaware's IMR decreased for the second consecutive period. From 2002-2006 to 2003-2007, IMR declined 3%, from 8.8 infant deaths per 1000 live births in 2002-2006 to 8.5 in 2003-2007. The rate is still too high especially when at looking at racial disparities. The data show a disparity in infant deaths among Black mothers compared to Caucasian mothers, with the largest disparity evident in Sussex County. At 16.9 deaths per 1,000 live births, the rate for Blacks in Sussex County is over three times as high as the rate for Caucasians, which stands at 5.0 per 1,000.

Reduce the Incidences of Low Birth Weight Births and Preterm Births. Infant low birth weight is a major predictor of infant mortality. Low birth weight babies are more likely than normal weight babies to have health problems during the newborn period. Low birth weight babies may also suffer from Respiratory Distress Syndrome and require additional oxygen and mechanical ventilation to breathe until their lungs mature. Other problems common in low birth weight infants include neurological problems, weakened immune system, and difficulty regulating body temperature, eating and gaining weight. In addition, low birth weight infants are at risk for experiencing Sudden Infant Death Syndrome.

Delaware has the eighth worst infant low birth weight percentage in the nation. The percentage of low birth weight infants born in Delaware continued to increase in the early 2000s to 9.28% in the 2003-2007 period.

Preterm birth is the leading cause of infant mortality and morbidity in the United States. Preterm-related deaths account for more than one-third of all infant deaths, and more infants die from preterm-related causes than any other cause. Proper birth spacing is found to be a factor in preterm birth and a maternal health indicator. Health professionals' consensus is that minimum birth intervals of two years are important for infant, child and maternal health. Interpregnancy intervals (IPIs) of less than 6 or 12 months are associated with an increased risk of preterm birth. A meta-analysis of 67 studies showed IPIs shorter than 6 months were associated with increased risks of preterm birth, low birth weight deliveries, and small-for-gestational age (SGA) infants compared with interpregnancy intervals of 18 to 23 months.

Reduce the Prevalence of Child/Teen Obesity and Overweight. A child's weight status is determined based on an age- and sex-specific percentile for BMI rather than by the BMI categories used for adults. Classifications of overweight and obesity for children and adolescents are age and sex specific because children's body compositions vary as they age and vary between boys and girls. The definition for being overweight or obese is:
• Overweight is defined as a BMI at or above the 85th percentile and lower than the 95th percentile.
• Obesity is defined as a BMI at or above the 95th percentile for children of the same age and sex.

The 2007 NSCH data indicated that for children ages 10-17 years nationwide, 32% are overweight (between the 85th and 95th percentile BMI-for-age) or obese (at or above the 95th percentile BMI-for-age). The 2007 NSCH reported that 35% of male children ages 10-17 years nationwide were overweight or obese compared to 27% of female children ages 10-17 years nationwide. For NSCH, 33% of children ages 10-17 years in Delaware were overweight or obese in 2007. According to the 2007 NSCH, 34% of male children ages 10-17 years in Delaware were overweight or obese compared to 32% of female children.

Reduce the Prevalence of Obesity Among Women of Childbearing Age. Data from the National Health and Nutrition Examination Survey indicate that the prevalence of obesity among women has slightly increased over time from 33% in 2003-2004 to 35% in 2005-2006. The National Center for Health Statistics indicates that in 2006, 62% of all women over age 20 were overweight. Black non-Hispanic women had the highest prevalence of obesity and overweight (80%), followed by Hispanic women (73%) and White non-Hispanic women (58%). The total cost of obesity and overweight in the U.S. in 2001 was $117 billion, $61 billion in direct cost, and $56

billion in indirect costs. Delaware BRFSS data indicate that 63% of residents between ages 18 and 64 are overweight or obese. Twenty-three percent (23%) of adult women in Delaware are considered obese.

Specific demographic characteristics are associated with obesity and overweight such as increasing age, race, childhood poverty, less education, and marital status. Health conditions causing obesity and overweight include food cravings, hormone changes, pregnancy, depression or anxiety, physical inactivity, stress, stressful life events, personality disorders, lifetime tobacco use, self-rated health, and body image. Weight gain among woman was more likely to contribute to a poor health self-rating compared with women who do not gain weight. Chronic conditions associated with obesity and overweight include hypertension, diabetes, and other metabolic disorders.

Reduce the Incidences of Unintentional Injury and Mortality among Children and Youth. The term covers a wide variety of incidents that occur from intentional and unintentional events which result in injury or death. Injuries can result from such things as motor vehicle accidents, falls, choking, firearms, fires, poisoning, athletic events, to name a few. Injuries may be severe enough to cause death. Once children reach the age of five years, unintentional injuries are the biggest threat to their survival. Risk for injury death varied by race. Injury death rates were highest for American Indian and Alaska Natives and were lowest for Asian or Pacific Islanders. Overall death rates for Whites and Blacks were approximately the same.

In Delaware in the 2003-2007 period, unintentional injuries comprised 18.43% of the deaths for children between ages 1-19 years. Moreover, in the 2003-2007 period, unintentional injuries were the leading cause of mortality representing 29.3% of deaths (17 of 58 deaths) for ages 1-4 years, 26.1% of deaths (18 of 69 deaths) for ages 5-14 years, and 55.3% of deaths (105 of 190 deaths) for ages 15-19 years.

Reduce the Prevalence of Teen Smoking. Teen tobacco use includes smoking (cigarettes, cigars) and the use of smokeless tobacco. Most adults addicted to tobacco in the United States started smoking during adolescence, and without intervention, most current teenage smokers can be expected to continue smoking into adulthood.

The 2009 Delaware YRBS reported that 47.7% of students tried cigarette smoking at one point in their life, 19.0% smoked cigarettes on one or more of the past 30 days, 11.9% smoked at least one cigarette every day for 30 days, and 6.8% used chewing tobacco, snuff, or dip on one or more of the past 30 days. These results parallel nationwide rates (50.3% of students nationwide tried cigarette smoking at one point in their life, 20.0% smoked cigarettes on one or more of the past 30 days, and 7.9% used chewing tobacco, snuff, or dip on one or more of the past 30 days using 2007 U.S. YRBS data). Overall, 23.2% of Delaware students have used tobacco in some manner at least one in the past 30 days. In addition, 13.7% (13.8% of males and 13.2% of females) had smoked a whole cigarette for the first time before age 13 years. Among students who reported current cigarette use, 47.4% (43.8% of males and 51.4% of females) tried to quit smoking cigarettes during the past 12 months.

Enhance Family Support of Children and Youth with Special Health Care Needs. Family support of children and youth with special health care needs (CYSHCN) is a multi-faceted approached to ensure parents, siblings and extended family have the resources, information, social support through informed networks and emotional support to care for a child with special needs. Family support must be family-centered -- it must meet them where they are and provide what they need in a culturally and linguistically appropriate manner. Since it is a diverse service and a one size fits all approach will fail, DPH MCH program has undertaken a year long stakeholder-led initiative to determine the needs and approach to better meet the diverse support needs of families. The result is the development of an umbrella organization, called the Family Support Initiative, which has been described extensively in other sections of the narrative.

Ensure the Early Detection of Developmental Delay. Developmental delays differ from other types of learning disabilities in that they may improve with intervention and may eventually disappear. For that reason, it is important to be aware of early signs of a problem. Developmental delays can exist in one or more of the following: behavior; cognitive skills; communication; emotional skills; fine and gross motor skills; and social skills.

Decrease Disparities among Families of Children and Youth with Special Health Care Needs. Disparities among families with CYSHCN are becoming increasingly evident every year. Research shows that a number of key disparities have been identified for Children with Special Health Care Needs (CSHCN) when compared to their peers without special needs. These disparities are most pronounced in four key areas: Child Health Indicators; Emotional and Mental Health Indicators; Health Care Access and Quality Indicators; and Family Health Indicators.

Improve the Availability of Dental Services (Preventive and Treatment) for Children. Delaware is taking steps to reduce the shortage of oral health access. The DPH's Oral Health Program, the Delaware Dental Society, the Delaware Oral Health Coalition, and the Delaware Dental Hygienists Society all collaborate to provide support to increase access to dental prevention and treatment.

Determining the Importance, Magnitude, Value, and Priority of Competing Factors

As a Title V Maternal and Child Health Block Grant funded agency, the Delaware Department of Health and Social Services (DHSS), Division Public Health is required to conduct a comprehensive needs assessment every five years. Delaware's 2010 Needs Assessment serves as a road map to guide program activities, resource allocation and impact evaluation for programs and services that target MCH populations.

The goal of the needs assessment is to assess the health status of women, infants, children, adolescents, and CYSHCN through the lens of the most up-to-date epidemiologic data, evidence-based practice, and population self-reported needs. It also provides a framework for program activities by outlining state health priorities, indicators, objectives, and activities. The State of Delaware envisions the 2010 Needs Assessment as a living document for guiding and measuring programs and services over the next five years. As such, the Delaware 2010 Needs Assessment represents the first step in a cycle of continuous improvement of maternal, child, and adolescent health. Between 2010 and 2015, actions and strategies will be implemented, results will be monitored and evaluated under the State Performance Measures included in this application, and necessary adjustments will be made in an effort to enhance the health of women, children, and adolescents in Delaware.

The MCH Director (Ms. Alisa Olshefsky, MPH) led the Delaware 2010 Needs Assessment process. Ms. Olshefsky serves as the Chief of Family Health and Systems Management within the Delaware Division of Public Health. She began outlining the process and timeline for the needs assessment in March 2008. This included conducting a thorough environmental scan of all MCH programs and services DPH provided, either directly or indirectly. The scan also organized programs by the MCH service delivery pyramid (i.e. direct, enabling, infrastructure, or population-based service) and included information on the target populations, outputs, funding sources, evidence base for the program, and whether a formal evaluation had been conducted.

The Center for Family Health Research and Epidemiology (Center) within the Family Health and Systems Management Section conducted thorough reviews of the literature and provided epidemiologic analyses. The Center contracted with APS Healthcare to conduct epidemiologic research and evaluation that was beyond the capacity of Center staff.

Family leaders and advisors to the MCH Children and Youth with Special Health Care Needs Program were key in ensuring the MCH Needs Assessment Workgroup and process was inclusive of family input and insight. Over the course of six months, the workgroup maintained at

least 25% representation of families at all meetings. This accomplishment was due to the outstanding work of Family to Family, a CYSHCN family-led organization through the University of Delaware, Center for Disabilities Studies.

In addition to family members, the composition of the workgroup (n=35) included executive leadership from DPH, program managers from Child Health, Early Childhood, State Systems Development Initiative, Newborn Metabolic Screening, Newborn Hearing, WIC, Immunizations, Adolescent and Reproductive Health, Primary and Rural Health Care, Health Statistics and staff from Community Health Services including Northern Health Services Clinics, Southern Health Services Clinics and the Oral Health Program. Representation from the Division of Child Mental Health Services, Children and Families First and the March of Dimes also participated on the workgroup.

A range of quantitative and qualitative resources were used to assess the strengths and needs of each of the MCH populations (infants, children ages 1-22, children and youth with special health care needs and pregnant women). Quantitative data collection included meticulous searches through vital statistics, population-based surveillance, and program evaluation data. Qualitative data collection included structured interviews, surveys, and client observation.

Although all of the health priorities identified by stakeholders through the six-month assessment process are important, the MCH program and DPH do not have the capacity to address them all. In order to systematically analyze the Division's capacity, the workgroup chose to use the HRSA CAST-5 system. CAST-5 is a methodology for assessing an organization's capacity to carry out core MCH functions. The internal MCH Needs Assessment Workgroup was trained on the CAST-5 system then completed an assessment on each of the essential services process indicators. In groups of two or three members, the teams scored the level of adequacy and capacity needs. Rich comments were provided on each process indicator through a SWON (strengths, weaknesses, opportunities and needs) analysis. This process was conducted over three meetings for a total of 12 hours.

The state priorities identified in this application for the 2011-2015 cycle were derived from a consideration of existing capacity and a Q-sort procedure applied to a total of 33 health conditions or health problems. These procedures are described in detail in the 2010 Needs Assessment Report included with this application. Given the diversity in background of the workgroup members, it was important they all had a baseline understanding of the epidemiology, severity, causes and strategies for each of the 33 health problems. Thus, informational fact sheets were created and distributed for workgroup review. These were modeled on fact sheets created by similar Title V programs (such as the program in Minnesota). Members were divided into six teams and each team was given five to seven health conditions on which to focus. Each individual did a ranking worksheet on all 33 health conditions. Then, as a group, they developed one consensus ranking worksheet on the five to seven assigned health conditions. This dual approach of individual and group review allowed for all members to be engaged on each health condition while still focusing on those that most impacted/interested them.

Note: References for the Overview, Health Status Indicators and Health System Capacity Indicator narratives are attached to this section.

An attachment is included in this section.

B. Agency Capacity

State Program Collaboration and Coordination

The Title V Maternal and Child Health Program partners with numerous other state and community-based agencies to advance its mission to improve the health and wellness of preconception and pregnant women, children and children with special health care needs and their families. This collaboration takes place at a number of levels within the Family Health and Systems Management Section, as well as at the Division (Public Health) and Departmental (Health and Social Services) Levels.

At the highest level, health policy is driven by the Health Care Commission. The Delaware Health Care Commission embodies the public/private efforts which have traditionally spelled success for problem solving in Delaware. Four government officials - the Secretary of Finance, Secretary of Health & Social Services, Secretary of Children, Youth & Their Families and the Insurance Commissioner - are joined by six private citizens appointed either by the Governor, the Speaker of the House or the President Pro Tempore of the Senate. The composition is a balance between the executive and legislative branches of government and the public and private sectors.
By creating the Commission as a policy-setting body the General Assembly gave it a unique position in state government. It is intended to allow creative thinking outside the usual confines of conducting day-to-day state business. The Commission is expressly authorized by statute to conduct pilot projects to test methods for catalyzing private-sector activities that will help the state meet its health care needs. To achieve its goals, the Commission strives to balance various viewpoints and perspectives.

The Commission generally has followed a strategy built on the notion that initial efforts should target areas most in need and gradually build toward a more comprehensive plan. Since 1995, the Commission has used a committee system as a means of reaching out to the community and involving those impacted by its decisions in the consensus building process.

The leadership of the Division of Public Health is also served by a number of advisory committees/councils that provide input on a variety of health topics. Specific to Maternal and Child Health are two committees -- the Delaware Healthy Mothers and Infants Consortium, a governor appointed body charged with the reduction of infant mortality and the Teen Pregnancy Prevention Advisory Committee, a body appointed by the Director of the Division of Public Health. Staff from Family Health and Systems Management, including the Maternal and Child Health Bureau provide staff and logistical support to both of these committees.

Under Family Health and Systems Management leadership there are committees that are specifically charged with issues affecting Children with Special Health Care Needs (Coordinating Council for Children with Disabilities; Family Support Network), early childhood (Early Childhood Comprehensive Systems Advisory Committee); newborn bloodspot screening (Newborn Screening Advisory Committee), newborn hearing screening (Delaware Hearing Assessment and Intervention Program Advisory Board), and the birth defects and autism registries (Birth Defects and Autism Registry Advisory Board).

Each of these committees consist of representatives from community-based agencies, other state agencies and family members of affected populations and provide critical input into MCH-related programs and activities.

Preventive & Primary Care Services for Pregnant Women, Mothers and Infants

Currently, preventive and primary care services for pregnant women, mothers and infants are supported through Title V Maternal and Child Health Block Grant and state general funds in statewide programs for pregnant women, women of reproductive age, infants, children and adolescents. Historically, these programs have included the home visiting programs Smart Start and Kids Kare. Smart Start is a prenatal program for at-risk pregant women and Kids Kare

provides support for families with children who are at risk for delayed development. These programs are currently being merged into a new evidence-based program model under the Healthy Families America framework, Smart Start which will serve at-risk pregnant women and children.

Over the past, the Family Practice Team Model and the Preconception Care Program have been merged into Healthy Women, Healthy Babies, a program that serves women at the preconception, prenatal and interconception periods. In this program, women are screened for risk factors in four domains: nutrition, social, mental health and medical. Once enrolled, pregnant women are seen at least monthly throughout their pregnancy and depending on their risk factors, provided information and education on topics including domestic violence, reproductive health, labor and delivery, alcohol, substance and tobacco use, and post partum issues.

Other programmatic efforts that offer preventive and primary care services for women and infants include WIC, Family Planning, and services offered on-site at Public Health clinics throughout the state.

As part of the research completed in the design and implementation of both the Family Practice Team Model and Preconception Care programs, the State of Delaware created a Registry for Improved Birth Outcomes. The registry, compiled from all births in Delaware occurring over during the past two decades, has helped to identify key risk factors associated with poor birth outcome (prematurity, low-birth weight and infant mortality). These factors include smoking, maternal weight (either too low or too high), chronic disease and short intervals between pregnancies.

The Newborn Metabolic Screening Program offers initial and confirmatory (second) screening for 37 conditions for every infant born in Delaware. The Newborn Metabolic Screening program also offers follow-up case management of positive screens to ensure identified infants and their families are linked to appropriate treatment services.

In the Spring of 2010, DHHS Secretary Sebelius released recommendations to screen for 30 core conditions. Currently, Delaware screens for 29 of these conditions. The one condition that is not currently included in Delaware's 37 conditions is Severe Combined Immunodeficiency Disease (SCID). In June of 2010, the state's Newborn Screening Advisory Council recommended that Delaware should investigate SCID screening, costs, equipment and staffing requirements. A final decision on this matter is expected later this year.

The Newborn Hearing Screening Program offers universal screening. Currently, the program screens over 93% of infants born in the state. The program also manages a hearing aid loaner program for children until a source is identified to obtain their own hearing aid.

Services for CSHCN

In Delaware, Children with Special Healthcare Needs (CSHCN) are served by the Birth to Three program for infants and toddlers aged 0-3 and by Kids Kare for children to age 21. The mission of the Birth to Three Early Intervention System is to enhance the development of infants and toddlers with, or at risk for disabilities or developmental delays, and to enhance the capacity of their families to meet the needs of their young children. Child Development Watch (CDW) is the statewide early intervention program under the Birth to Three Early Intervention System. CDW is a collaborative effort with staff from the Division of Public Health, the Department of Services for Children, Youth and Their Families, the Department of Education and the Alfred I. DuPont Hospital for Children working together to provide early intervention to young children with special health care needs and their families.

CDW is evaluated on an ongoing basis. One of the evaluative tools is the annual Family Survey which is conducted via telephone with a stratified random sample of families based on geographic

region, ethnicity and length of time in the program. The 2007 survey found:
- 97% of families indicated that they had overall satisfaction with the services they received;
- 94% of families perceived the program as accessible and receptive;
- 93% of families perceived change in themselves and their family;
- 93% of families perceived change in their child;
- 93% of families reported a positive perception of family decision-making opportunities;
- 92% of families reported a positive family-program relationship with CDW staff; and,
- 92% of families reported a positive perception of their quality of life.

The Child Development Watch (CDW) Program provides developmental assessments to children birth to 3 years of age and service coordination for developmental services and therapies. According to an annual University of Delaware survey, 95.9% of families perceived the CDW program as accessible and receptive, while more than 92.5% perceived change in their child's abilities. As of the end of FY09, CDW has case managed 3,094 children statewide; 1,875 are served by the NHS' CDW office. An additional 124 children will be re-evaluated.

CDW strives for compliance with federal timelines despite high caseload numbers. This year, CDW North achieved 90% for providing services within 30 days. In a study sample of 236 children, 78% of CDW children with skills below age expectations made gains by their discharge date. Forty-seven percent of these children are functioning at age level upon discharge.

CHILD DEVELOPMENT WATCH (CDW) RECOGNITION -- Southern Health Services' Child Development Watch (CDW) staff surpassed their federal 45-day timeline standard from date of referral to delivery of individual family service plans (IFSP) by reducing the interval to 39 days by year's end. While 55% of the Family Service Coordinators were compliant at the beginning of 2009, 83% attained this standard by December. Success is correlated with the systematic implementation of individual and group data feedback provided by the management analyst and supervisors.

CDW PROGRAM AWARENESS -- Dr. Carol Owens, Developmental Pediatrician, and Jennifer Donahue, Trainer/Educator, formed a professional outreach committee to encourage physician referrals to the CDW Program. They provided Kent and Sussex County physicians with resources, information and opportunities for collaboration. A practice can elect to receive one or all of the following: a CDW Program manual; one-on-one or group training; one-time contact or monthly contact to discuss referrals. To date, response is lower than expected. New approaches are being considered.

The Office of Children with Special Health Care Needs, as part of Delaware's Maternal and Child Health program in the Division of Public Health, has a long history of family/professional partnerships by working closely with families and family-led organizations. Since 1993, Delaware's Birth to Three system in coordination with the Office of CSHCN have developed practices of family-centered care that have become part of the culture for DPH in addressing the needs of families of young children with special needs.

Child Development Watch utilizes a community team model. The CDW team includes members from the Division of Family Services, the Division of Management Services, the Department of Education, the Division of Developmental Disabilities Services and contractual staff to ensure children and families are linked with the appropriate array of services. The model also includes specialized community services provided in early education centers and daycare settings, where CDW provides outreach to care providers for educational purposes and follow-up services for Children with Special Health Care Needs.

Current efforts to provide coordination to youth transitioning to adult services include Delaware's Transition Initiative that sponsored a survey of youths moving to adult services in the community. Based in part on the research that found youth have difficulty securing specialty care in the adult community, A. I. duPont Hospital for Children of the Nemours Foundation has created an Office

of Transition and clinical team to meet the needs of youth transitioning to adult community services. The Office of Transition team includes a nurse, a part-time medical doctor, a social worker, and support staff. It will be operational in summer, 2008. In addition, the Office of CSHCN also supports expansion of Internet based tools for families and youth with special health care needs. Through a contract with the University of Delaware's Center for Disability Studies, Delaware's website for transition information continues to be updated to include specific contact information for medical and social needs.

Cultural Competence

In 2007, the Delaware Division of Public Health (DPH)/DHSS contracted with the Center for Health Equality (CHE) at Drexel University's School of Public Health to conduct a cultural competence assessment of the division. The primary project objective was to apply a health care cultural competence protocol that was adapted, with the assistance of DPH staff, to the priorities and characteristics of the division. The process called for interviewing administrative, management and program personnel identified by the DPH, obtaining and ordering cultural competence-related materials across programs, and scoring and scaling the division according to the assessment's five-point "Spectrum of Cultural Competence."

In addition to the relative strengths of DPH in striving for cultural competence, the report identified areas for improvement. These areas include:
- Services tend to operate independently of each other and, as a result, there was little opportunity to engage across them or to learn from their experiences or initiatives.
- Insufficient resources to provide important cultural competence services, including restrictions and requirements regarding dollar allocations, limit scope and reach and make it difficult to prioritize cultural diversity given other pressing needs.
- From staff in administration and direct service there was very little to no information gathered related to a formal process for collecting and monitoring client based race and ethnic data. Direct service staff do not have a formal mechanism for capturing client language needs in electronic databases. Although individual programs have added this information to their intake questionnaires, these data are not captured for administration to observe trends in demographic shift of clients.
- Although, there were many connections to the community, most of the work to incorporate community was project specific and oriented toward direct service personnel.

To address these challenges, the DPH Office of Minority Health and the Office of Workforce Development have developed an ongoing training half day training, "DPH: Journey to Cultural Competence." The training is filled with rich discussion and interactive activities to help DPH employees increase cultural awareness to better serve our customers, clients, patients and co-workers. In 2009, approximately 163 professionals attended the training and gave overwhelmingly positive evaluations.

In 2008, the Office of Minority Health released a Health Disparities Report Card that was designed to show the health disparity gaps among Delaware's racial and ethnic minorities, and to help monitor the community's and state's progress in eliminating those gaps.

Leading health and related indicators for broad racial and ethnic populations were included, along with supporting data and a letter grade to rank the health status of those groups.

This report card's aims are to:
• Inform the public and professionals, helping to guide them as they develop strategies, plans and programs to eliminate health disparities;
• Provide data to guide services and outreach provided by community-based organizations, faith-based organizations, state agencies and organizations, legislators, businesses, health care providers and hospitals; and
• Inform key decision makers on eliminating health disparities through policy reform and systems

change.

Recent Legislation (2009-2010)

In the current legislative session ending 6/30/2010 several notable bills were signed into law.

House Bill #44. This bill authorized the State Fire Prevention Commission to incorporate a non-profit, non-stock corporation known as the Delaware Burn Camp Corporation for the purpose of establishing, administering and operating and overnight camp devoted to helping burned children cope with the emotional and physical issues from their injuries.

House Bill # 328. This bill requires courts, administrative tribunals, school districts, and schools to use the definition of "free and appropriate education" with respect to disabled children that has been enumerated for this region of the country by the United States Third Circuit Court of Appeals in Ridgewood Board of Education v. N.E., 172 F.3d 238 (3d. Cir. 1999).

Free appropriate public education' means special education that is specially designed instruction including classroom instruction, instruction in physical education, home instruction and instruction in hospitals and institutions, and related services as defined by Department of Education rules and regulations approved by the State Board of Education and as may be required to assist a handicapped person to benefit from an education that:

a. Is provided at public expense, under public supervision and direction and without charge in the public school system;

b. Meets the standards of the Department of Education as set forth in this title or in the rules and regulations of the Department as approved by the State Board;

c. Includes elementary, secondary or vocational education in the State;

d. Is individualized to meet the unique needs of the handicapped person;

e. Provides significant learning to the handicapped person; and

f. Confers meaningful benefit on the handicapped person that is gauged to the handicapped person's potential.

Delaware's Children's Health Insurance Program (CHIP) was extended to include reduced-cost health insurance coverage for children of families with personal incomes above 200% of the Federal Poverty Level.

A law requiring the developmental screening of infants and toddlers has been signed. This law equires that private health insurers in Delaware cover the developmental screenings for infants and toddlers that are recommended by the American Academy of Pediatrics and the Delaware Early Childhood Council. Such screenings have historically been covered for children in the state's Medicaid program. The estimated cost to policyholders of covering these screenings is three cents per member per month.

A law to expland access to dental care for children with disabilities was signed. Parents of children with severe disabilities experience difficulty in identifying practitioners willing and able to provide effective dental care. Strict application of "in-network" insurance restrictions exacerbates the parents dilemma since there may be no nearby in-network dentist willing and able to treat their child. When parents with secondary child Medicaid insurance are unable to effectively access private dental insurance, the result is an increase in Medicaid claims. This bill only applies to insurers which include dental services in their benefits package. It allows parents with such private dental insurance to secure dental care for a child with a severe disability irrespective of

"in-network" restrictions. Finally, it promotes the availability of in-network practitioners willing and able to treat such children.

On June 30, 2010, House Bill 283 was sent to the Governor and is awaiting signature at the time of submission of this application. HB 283 creates a "Hearing Bill of Rights" for school-aged children who are deaf or hard of hearing. Specifically, the bill allows deaf and hard of hearing children to receive instruction in more than one communication mode or language.

C. Organizational Structure

Governor Jack Markell heads the executive branch of Delaware's state government.
The Delaware Department of Health and Social Services (DHSS) is among the cabinet-level agencies in the executive branch. DHSS is led by Secretary Rita Landgraf.

The Delaware Department of Health and Social Services is the largest state agency, employing almost 5,000 individuals in a wide range of public service jobs. The department includes 12 divisions, which provide services in the areas of public health, social services, substance abuse and mental health, child support, developmental disabilities, long term care, visual impairment, aging and adults with physical disabilities, and Medicaid and medical assistance. The Department includes four long term care facilities and the state's only psychiatric hospital, the Delaware Psychiatric Center.

The Division of Public Health is the largest division within DHSS and Is under the direction of Karyl T. Rattay, MD. In Delaware, there are no county/local health departments. DPH administers both state and local public health programs. DPH is structured into three main strands: Operations, Health Information and Science (HI&S), and Community Health Services. The Title V Maternal and Child Health (MCH) Block Grant program and the Children with Special Health Care Needs (CSHCN) program are part of the Family Health and Systems Management Section (FHSM), within the HI&S strand. HI&S is led by Paul Silverman, Dr.PH. Alisa Olshefsky, M.P.H. is the section chief for FHSM, as well as the state MCH Director. Within FHSM, the Bureau of Maternal & Child Health is led by the MCH Deputy Director, Leah Jones, MPA. The Bureau includes the Title V Block Grant, the Newborn Screening program, the Newborn Hearing program, the Genetics program, Early Childhood Comprehensive Systems, and the State Systems Development Initiative, and Children with Special Health Care Needs. The Bureau of Adolescent and Reproductive Health, under Gloria James, Ph.D. includes the Adolescent Health Program (which includes School-Based Wellness Centers and Teen Pregnancy Prevention) and the Title X Family Planning Program. The Bureau of Health Planning & Resources Management, led by Judith Chaconas includes the Offices of Primary Care & Rural Health and the J-1 Visa program. The Center for Family Health Research and Epidemiology, led by Mawuna Gardesey, M.B.A. includes the Infant Mortality Elimination Program. (See attached Organization Chart).

Nurses, social workers and nutritionists within the Smart Start, Kids Kare, and Child Development Watch Programs are directed by Herman Ellis, MD and Kristin Bennett, RN., MSN. Beyond the FHSM section, several other critical programs are part of the MCH array of services and programs. These include Oral and Dental Health Services; Northern Health Service Clinics, led by Anita Muir, M.S.; and Southern Health Clinics, led by Sherry Eshbach. Northern and Southern Health Services Clinic sites are the providers of three primary programs funded by Title V funds: Smart Start, Kids Kare (currently being integrated into Smart Start) and Child Development Watch. The state Public Health Nursing Director is Kristin Bennett, PhD., RN. DPH also includes a number of other programmatic areas which work closely with the MCH array of programs and activities. These programs are located throughout the strands of DPH and include Immunizations, Sexually Transmitted Diseases, Emergency Medical Services for Children, and the WIC program.

The total Maternal and Child Health Partnership budget reported in this application includes Title V funds, state general funds and appropriated special funds. Staff are funded through each of the

three sources of funds. This year's Title V funds includes $1,814,303 for 29.4 FTEs (2.0 FTES are projected to remain vacant during FY 2010). State general funds and appropriated special funds from Oral Health revenue will pay for 72.0 FTEs (a total of $4,989,395) and contractual funds under the Infant Mortality Elimination program (a total of $4,600,000).

An attachment is included in this section.

D. Other MCH Capacity

Senior level / lead staff for the MCH Block Grant are:

Alisa Olshefsky, MPH. Alisa serves as the state Maternal and Child Health Director and is the Section Chief for Family Health and Systems Management. Alisa is in her third year serving in these capacities. Prior to assuming section chief responsibilities at the Division of Public Health, Alisa served as a Bureau Chief for Chronic Disease from 2006-2008 where she built and sustained the Delaware Cancer Consortium, a public/private collaborative. Alisa also has past experience as an Evaluation Manager at the University of California (San Diego), Division of Community Pediatrics.

Leah A. Jones, M.P.A. is the Maternal and Child Health Bureau Chief and MCH Deputy Director. Leah is responsible for direct oversight of the Title V Maternal and Child Health Block Grant Program, the State Systems Development Initiative, the Children with Special Health Care Needs Program, Early Childhood and Comprehensive Systems, the Autism Registry and the Birth Defects Registry and the Newborn Screening Programs (Metabolic and Hearing). Leah joined the Division of Public Health this year in the Spring. Leah's prior experience includes serving as the Director of Planning & Policy for the Delaware Health Care Commission. In the past administration, Leah worked as the Executive Assistant to Cabinet Secretary of Delaware Health and Social Services. Leah also served as the Caregiving Program Administrator for the Division of Services for Aging and Adults with Physical Disabilities.

Parents of Children with Special Needs. Beth MacDonald, a CSHCN parent, is the Special Needs Alert Program (SNAP) program coordinator. Additionally, the MCH Program works closely with Family 2 Family, Delaware Family Voices, Delaware Hands and Voices and each of the organizations involved with the Family Support Initiative to ensure parent / family involvement in planning and evaluation of initiatives focused on Children with Special Health Care Needs.

Staff Dedicated to the Maternal and Child Health Block Grant

Staffing for the Title V programs includes 29.9 FTEs supported with Federal Title V funds and 72 FTEs supported by State General Funds (65 FTEs) and Appropriated Special Funds (7.0 FTEs).

Postions included as part of the Federal-State MCH Partnership are distributed as follows:

- 10 Administrative Specialists
- 10.5 Advanced Practice Nurses
- 1 Section Chief (MCH Director)
- 1 Clinic Aide
- 4 Clinic Managers
- 1 Community Relations Officer
- 9 Dental Assistants
- 6 Dentists
- 1 Genetics Coordinator
- .5 Health Program Coordinator
- 1 Management Analyst
- 3 Medical Records Technicians
- 1 Medical Social Worker Consultant

- 7 Nursing Supervisors
- 1 Nutritionist
- 3.0 Public Health Program Administrators
- .4 Public Health Physician
- 17.5 Registered Nurses
- 2 Senior Child Development Specialist
- 5.0 Senior Medical/Social Work Consultants
- 1 Social Worker
- 4 Social Service Specialists
- 8 Social Service Technicians
- 1 Teacher
- 1 Teacher's Aide
- 2 Trainers

These positions are located throughout the state's 9 Public Health Clinic Locations and work primarily in Smart Start, KIDS Kare, Child Development Watch and the Oral Health Program. Several positions (Program Administrators, Management Analyst, Section Chief) are centrally located in the DPH Administration Building in Dover, DE.

E. State Agency Coordination

Delaware prides itself in building and maintaining partnerships and collaborations with both state and federal organizations. Many organizations and coalitions are working to improve maternal and child health in the state of Delaware. Within DPH, a performance improvement initiative led by the Division Director is re-focusing the organizations priorities to focus on core services within public health and specific health priorities. The aim is to have DPH working at the "bottom of pyramid" on population-based and infrastructure-building services. The four Division priorities include:

- Healthy lifestyles
- Health reform
- Disparities elimination
- Organizational development

These priorities are addressed in part through the follwowing relevant relationships between the Division of Public Health/Title V MCH Program and external partners.

Delaware Healthy Mother and Infant Consortium. The targeted effort of providers, DPH, and the Delaware Healthy Mother and Infant Consortium (DHMIC) and its subcommittees to reach pregnant women and mothers is very successful. In 2008, the prenatal programs reached almost 20% of all pregnancies in Delaware.

Child Death, Near Death and Stillbirth Commission (CDNDSC). Delaware's child death review process was established by legislation passed on July 19, 1995, after a pilot project showed the effectiveness of such a review process for preventing future child deaths. The statute was amended in 2002, and again in 2004, changing the name from the Delaware Child Death Review Commission to the Child Death, Near Death and Stillbirth Commission (CDNDSC). The mission of the commission is to safeguard the health and safety of all Delaware children as set forth in 31 Del. C. c. 3. The key objectives are:

• Review in a confidential manner, the deaths of children under the age of 18, near-deaths of abused and/or neglected children and stillbirths occurring after at least 20 weeks of gestation.
• Provide the Governor, General Assembly and Child Protection Accountability Commission with recommendations to alleviate those practices or conditions that impact the mortality of children.
• Assist in facilitating appropriate action in response to recommendations.

The CDNDSC has the authority to create up to three regional child death review panels and three

regional Fetal Infant Mortality Review (FIMR) teams to conduct retrospective reviews of all child deaths, near deaths due to abuse/neglect and stillbirths (after 20 weeks gestation) that occur in the state. The Commission provides meaningful system-wide recommendations to prevent the deaths and/or near deaths of children and improve services to children. The process brings professionals and experts from a variety of disciplines together to conduct retrospective case reviews, create multi-faceted recommendations to improve systems and encourage interagency collaboration to end the mortality of children in Delaware.

CDNDSC/Fetal and Infant Mortality Review. Reviews every fetal and infant death in Delaware using the Fetal and Infant Mortality Review (FIMR) process, which includes reviewing medical records, death certificates and other health information, and interviewing mothers. FIMR helps to inform why there is a high number of fetal and infant deaths in Delaware. The information received from interviews with mothers helps make recommendations for changes in public health programs and interventions.

The top four issues identified in 2008-2009 were:
- preexisting medical conditions;
- medial and social services and community resources that were available and not used;
- obesity and poor nutrition;
- preterm labor.

More specifically, 71 percent of women interviewed had a preexisting medical condition, 40 percent had inadequate or delayed referrals for home-based services; 26 percent were obese and 24 percent had inadequate nutrition or anemia in the first trimester; and 32 percent went into preterm labor.
The DHMIC is the community action arm or implementation teams for FIMR findings.

In 2010 CDNDSC is collaborating with the Division of Public Health and Nemours to implement the National "Cribs for Kids Program" in Delaware. This program provides cribs and educational materials related to safe sleeping practices to mothers in need.

FIMR Infant Safe Sleeping Practice. In 2009: FIMR distributed Infant Safe Sleeping Posters to all licensed daycare centers in the state and continued community education on Safe Sleeping Practices as community events/trainings.

Delaware Birth Defects Registry. A statewide program that collects and analyzes information on children with birth defects. By collecting information for a statewide registry, Public Health officials hope to identify health, environmental and genetic risk factors which could lead to pinpointing the causes and prevalence of birth defects. The Delaware Birth Defects Registry is designed to collect information on children diagnosed under the age of five with a birth defect. The children are residents of Delaware or their parents are Delaware residents. Confidentiality is a key component of the program. All information is kept in utmost confidence using strict security measures.

March of Dimes. The March of Dimes-Delaware Chapter (MOD) works to improve the health of babies by preventing birth defects, prematurity and infant mortality. The mission is accomplished through research, community services, education and advocacy and collaborations with many organizations to save babies' lives. Delaware's MOD also is one of 15 chapters to support the NICU Family Support Program which provides direct service and support to families with infants in the NICU of Christiana Care. Through partnership, families are directly linked to community programs to assist with transition from hospital to home for the most vulnerable babies prior to discharge. DPH will continue to collaborate with the March of Dimes in a joint effort to increase access to quality prenatal care, reduce the number of premature births and birth defects and improve health outcomes of all children. The MOD staff serve on DHMIC committees.

Department of Education (DOE). The Delaware Health and Social Services and the Department

of Education work collaboratively to develop programs promoting the health of all children in Delaware. Examples include the delivery of EPSDT services in the school setting and in providing support for School-Based Health Centers. Currently there are commissions on Health Education, Health Services, and Physical Education, Nutrition Services, School Climate, Staff Wellness, and Counseling Services. The Coordinated School Health Program Team is composed of a variety of health and education related agencies, private, and public including parents. They recruited school applicants to participate in a needs assessment of health needs in their respective schools. After identifying the specific needs, plans were developed to target those needs. The DOE has also collaborated with DPH in development of the Part C early intervention efforts. Staff are also housed and incorporated into the CDW team and serve as liaisons for transition and Individuals with Disabilities Education Act (IDEA B and C) issues. The Office of Health Services, DOE, in partnership with the DPH provides training to school nurses on teen pregnancy prevention, lead poisoning, tuberculosis, immunizations, bio-terrorism and emergency preparedness and public health resources. Delaware has a comprehensive system of school nurses, with one in each school and most private schools. There are over 320 full and part time school nurses in Delaware that serve students in public and private schools.

Head Start and Early Childhood Assistance Program. Head Start is administered by DOE through community-based organizations throughout the state. There are three locations in Kent County, four in Sussex County, and twelve in New Castle County. Early Childhood Assistance Programs are state-funded, comprehensive child development programs for low-income families with children age four and eligible for kindergarten the following year. These programs follow the Head Start Performance Standards. Approximately 1,795 children between ages three and five are served by the traditional Head Start program. All programs followed the federal Head Start Performance Standards. The Division of Public Health participates on the Head Start State Collaboration project, which was established to develop state level partnerships for planning and policy development for Head Start eligible children and their families. Priority areas include welfare reform, health access, childcare, social and emotional wellness, disabilities, educational opportunities, volunteerism, literacy, and homelessness. The Head Start State Collaboration Office director serves on the ECCS steering and executive committees and Healthy Child Care America-Delaware (HCCA-DE) advisory committee. HCCA-DE and the Head Start State Collaboration Office partnered to provide funding and resources for the piloting of Partners In Excellence: Promoting Social & Emotional Competencies in Young Children (PIE) in 15 Head Starts, ECAPS and Child Care Centers statewide. An additional partner is the Devereux Foundation and one of the evaluation measures will utilize the Devereux Early Child Assessment (DECA) tool. This pilot worked with classroom teachers and parents to infuse PIE and DECA strategies into classroom curriculum to identify and minimize challenging behaviors. The pilot utilized child care health consultants as technical advisors in the classroom setting and will impact over 1500 children, between the ages of 3 to 5. In addition, Child Development Watch staff work with local Head Starts and other providers on the Sequence in Transition to Education in Public Schools (STEPS) Committee, which concentrates on transition issues for 3 year olds.

Early Success. The Department of Education's Early Care and Education Office is a key collaborator with the Division of Public Health on the early childhood comprehensive systems effort. Initiated in 1998, Early Success was developed as the state's coordinated plan to address the early childhood issues of children, birth to eight, who received out of home care. The governor established an interagency resource management committee made of the cabinet secretaries from the Department of Health and Social Services, Department of Services to Children, Youth and their Families, Department of Education, Office of Budget, and the Controller General's Office. Additionally, the governor established the Delaware Early Care and Education Council, comprised of private citizens, and the Office of Early Care and Education (OECE) to ensure that Early Success goals and objectives were met. In an effort to provide a comprehensive approach of early childhood services to all families, the ECCS and the OECE, with full support from the Delaware Early Care and Education Council, have partnered to unify Delaware's early childhood initiatives and broaden the initial Early Success plan to include child health, social-emotional development, and expand family engagement domains. This will provide

a statewide strategic plan that is comprehensive, coordinated and accessible to all children from birth to age five, and their families. It will also enable the DPH to provide statewide leadership on child health and development issues through multiple public/private collaborations.

Early Childhood Work Groups. The Early Childhood Education workgroup provides leadership to ensure that Delaware delivers an equitable and effective system of education for young children in full compliance with federal and state law. The group ensures that the interests of young children are represented in all aspects of Delaware's education reform. The group operates, oversees and monitors programs made possible by both federal and state funds.

The School Support Services workgroup includes programs and support services necessary to assure a supportive and healthy environment that nurtures academic growth and development. The group is responsible for the development of programs and services in the areas of:
• Nutrition Programs;
• School Climate and Discipline;
• School Health Services;
• Student Services and Special Populations.

Delaware Oral Health Coalition. Promotes good oral health through its Awareness and Prevention Committee and its Integrated Delivery Systems Committee. The Coalition was instrumental in developing the Oral Health Awareness Campaign. Members developed a curriculum for all health classes and presented it to the Delaware Department of Education for review. It also reviewed topics such as Medicaid enrollment for dentists, improving access to care in underserved areas, and expanding the dental residency program downstate.

DHSS Division of Management Services (DMS). Provides human resources, budget development, and evaluation services to other DHSS divisions. DMS also houses the Birth to Three Office, which provides administration for Part C. Birth to Three is a statewide, comprehensive, coordinated, multidisciplinary, interagency system that provides early intervention services and supports for infants and toddlers with disabilities and developmental delays and their families. DMS staff provides overall management for the system and ensures compliance with the federal requirements of the Individuals with Disabilities Education Improvement Act of 2004, which provides funding to help support the system.

Children and their families receive early intervention supports and services by Child Development Watch within the Division of Public Health, with staff drawn from DPH and DDDS. Major external partners, through interagency agreements and contracts, are Department of Education; Department of Services for Children, Youth and Their Families; Christiana Care Health Services, Inc.; Alfred I. duPont Hospital for Children; and community providers.

DHSS Division for the Visually Impaired (DVI). The DPH Child Development Watch works with DVI to provide service coordination for children with visual impairments or who blind.

DHSS Office of Emergency Medical Services. Delaware first received EMSC grant funding in 1997 and the program officially began with the hiring of a program coordinator in 1998. Some examples of cutting-edge work underway with support from the EMSC program are projects to: provide specific education and equipment for all levels of pediatric emergency care providers; ensure that Delaware EMS protocols are developed to meet the needs of children; to develop emergency care and disaster education and training programs for child care agencies; and ensure that all state trauma/disaster plans address pediatric needs. More detailed information on Emergency Services for Children is outlined in Section VI.

Department of Services for Children, Youth, and Their Families (DSCYF). Established in 1983 by the General Assembly of the State of Delaware and collaborates closely with the DPH. Its primary responsibility is to provide and manage a range of services for children who have experienced abandonment, abuse, adjudication, mental illness, neglect, or substance abuse. Its

services include prevention, early intervention, assessment, treatment, permanency, and after care. The KidsDepartment employs approximately 1,200 staff at 31 locations, who serve over 8,000 children on any given day. Among the workforce are 52 Family Crisis Therapists (FCTs), who work in elementary schools throughout the state. Additionally, the Department provides licenses to nearly 2,200 daycare operations, which provide services for more than 49,000 children in Delaware.

Division of Family Services (DFS). Services provided are child oriented and family focused. The Foster Care staff work with Delaware's foster families to protect and nurture children; meet the children's developmental needs and address developmental delays; support relationships between children and their families; promote permanency planning leading to reunification with the child's family or other safe nurturing relationships intended to last a lifetime. The Office of Child Care Licensing strives for a high standard of care and ensures safe environments for children by providing guidance, training and support to many day care providers throughout the state, and investigating complaints concerning day care facilities. The Division's Office of Children's Services also assesses families with problems and provides them with supportive services to empower them to protect and nurture their children.

Division of Youth Rehabilitative Services (DYRS). Provides services to youth who have been adjudicated delinquent and ordered by the court system to receive rehabilitative services. DYRS works closely with the community and DPH through the Community Advisory Board, DYRS serves approximately 5,000 youth per year, ranging from probation to secure care incarceration. In Delaware, there are five secure care facilities that provide secure detention for youth and 24-hour custodial care and treatment for incarcerated, adjudicated youth. Secure care also provides appropriate education, treatment, counseling, recreation, vocational training, medical care, and family focused case management for youth in secure residential facilities. Furthermore, the DYRS Community Services unit provides probation and aftercare services to approximately 3,000 youth per year, in addition to overseeing 47 contracts with providers offering residential and nonresidential programs and services. Community Services operate to ensure that the risks to the public is minimized, youth are served in the least restrictive environment appropriate for their needs, and the families of the youth are strengthened through Community Services intervention.

American Academy of Pediatrics (AAP). The DPH has established close partnerships with health professional programs including the Delaware Chapter of the American Academy of pediatrics (AAP). The AAP, Medicaid, and the Family Health Section have participated on the vaccine committee, EPSDT implementation committee, and lead poisoning prevention committee. The AAP has also been involved in the injury prevention efforts of DPH, Part C planning, the medical home project, and breastfeeding promotion as well as on a scientific committee addressing the problem of infant mortality.

The Delaware Coordinating Council for Children with Disabilities (DCCCD or CCCD) has been active as an advisory committee for the CYSHCN program. This has increased both the formal and informal interagency collaboration statewide.

The Autism Surveillance and Registration, or an Autism Registry. Enables the DHSS and DPH to collect basic descriptive information on the individuals with autism, to track changes in prevalence over time, to inform the planning of service delivery to children with autism and their families, and to facilitate autism research. The purpose of the Autism Registry is to provide an accurate and continuing source of data concerning autism to provide information to Public Health officials. The Autism Registry will gather data to assist with: prevalence estimation, cluster investigation, risk factor identification, and outcome assessment.

Section 619/Special Education for Ages 3-5 Coordinators: This program provides free appropriate public education (FAPE) for children, ages 3 through 5 years, with disabilities in Delaware.

State Interagency Coordinating Council (ICC). The ICC advises appropriate agencies on the

unmet needs in early childhood special education and early intervention programs for children with disabilities, assists in the development and implementation of policies that constitute a statewide system, and assists all appropriate agencies in achieving full participation, coordination, and cooperation for implementation of a statewide system.

CYSHCN Survey. To better understand the CYSHCN population and the needs and challenges they face, the CDC conducted a telephonic survey in 2005--2006 titled the National Survey of Children with Special Health Care Needs. The results did provide valuable information for Delaware but due to a small sample size and lack of a diverse sample, the results were not representative of CYSHCN in Delaware. The DPH is conducting an additional mixed method survey in 2010 to try to capture a broader and more representative sample. The CDC is aware of the survey and offered assistance if needed.

Transition of Care for CYSHCN. A major challenge to CYSHCN and their families is the transition into adult care. Collaborations exist between family members, physicians, therapists, educators, and service providers who belong to DCCCD, the Office of Children with Special Health Care Needs, DPH, and the Alfred I. duPont Hospital for Children Transition Committee to understand the struggles to navigate and transition to adult care for young adults with chronic conditions and disabilities. The Delaware Transition Initiative at the Alfred I. duPont Hospital for Children established the Transition Survey Project to further explore young adults and families issues when they transition from specialized pediatric health care systems into community-based adult health care systems. The major takeaways from the survey demonstrated the significant lack of specialized providers for young adults, the lack of assistance and education families and the youth receive about the process, and the lack of communication between current and future providers. The CYSHCN survey the DPH is conducting in 2010 is also addressing the transition issue and hopes to make positive changes in the near future.

Family Support Initiative (FSI): The FSI, or umbrella organization concept, was developed by the MCH Director in 2008 after a site visit with the Rhode Island MCH program. Rhode Island had a successful model for CYSHCN and family support services where an umbrella organization (Rhode Island Parent Information Network) helped convene and strengthen resources and services through a network of CYSHCN organizations. In Delaware, the goal is that the umbrella organization convenes partner organizations (either formal organizations or parent groups) whose work focuses on meeting the needs of CYSHCN. Partner organizations provide input and strategic guidance as part of an Advisory Council to the umbrella organization. CYSHCN are strongly represented as part of the organization's governance structure. The umbrella organization has the "bird's eye view" and works with partner organizations to decrease duplication in services, increase access to services and address unmet needs to ensure the system of CYSHCN family support is meeting the needs of families.

F. Health Systems Capacity Indicators

Introduction

In FY 2007, the Division of Public Health implemented a Center for Excellence in Maternal and Child Health Epidemiology. The primary responsibility of this unit is to conduct and collaborate on research initiatives related to Maternal and Child Health with an emphasis on Infant Mortality and Poor Birth Outcomes. The Center works closely with the State Vital Statistics Office and Medicaid to study and monitor measures related to maternal and child health and associated health systems capacity indicators. Center staff provides expertise on research, data and statistics and share information internally with other Title V staff, as well as with numerous other partners in the Division, State and larger community. The Center's name was changed in 2009 to the Center for Family Health Research and Epidemiology. During the past year the Center has contracted with APS Healthcare to provide research and consulting on epidemiological studies related to maternal and child health. In addition to the Center, the state's State Systems Development Initiative (SSDI) provides resources for ad hoc reports involving multiple databases (Vital Statistics, PRAMS, Newborn Screening, etc.).

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	69.1	69.1	63.2	63.2	63.2
Numerator	378	378	362	362	362
Denominator	54668	54668	57303	57303	57303
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data are not availalbe at this time. The data reported are from the 2007 Hospital Discharge Data.

Notes - 2008
2008 data are not availalbe at this time. The data reported are from the 2007 Hospital Discharge Data.

Notes - 2007
Data reported by Delaware Health Statistics Office for 2007 (Hospital Discharge Data).

Narrative:
Asthma is a major public health problem of increasing concern in the United States. From 1980 to 1996, asthma prevalence among children increased by an average of 4.3% per year, from 3.6% to 6.2%. Low-income populations, minorities, and children living in inner cities experience disproportionately higher morbidity and mortality due to asthma (CDC, 2009).

While the number of adults with asthma is greater than the number of children with asthma, the asthma rate is rising more rapidly in preschool-aged children than in any other group. Asthma is the leading serious chronic illness of children in the U.S. In 2006, an estimated 6.8 million children under age 18 (almost 1.2 million under age 5) currently had asthma, 4.1 million of which had an asthma attack, and many others have "hidden" or undiagnosed asthma. In 2006, the highest current prevalence rate was seen in those 5-17 years of age (106.3 per 1,000 population), with rates decreasing with age. Overall, the rate in those under 18 (92.8 per 1,000) was much greater than those over 18 (72.4 per 1,000) (American Lung Association, n.d.).

National indicators for asthma include the Healthy People 2010 leading health indicator: 24 Promote respiratory health through better prevention, detection, treatment and education efforts. Prevention and care of diseases caused by an unhealthy environment is a Healthy Delaware 2010 goal.

The following programs exist in Delaware to ensure a healthier environment.

• The Department of Natural Resources and Environmental Control (DNREC) monitors six air pollutants, and produces an Air Quality Index (AQI), which is available on the DNREC website. The report shows the number of days the AQI is rated unhealthy for sensitive individuals.

• DNREC also monitors pollutants called Fine Particulate Matter, which are dangerous because they can penetrate more deeply into the lungs than large particles. Delaware has not been able to comply with the National Ambient Air Quality Standards for Fine Particulate Matter, because New Castle County's yearly average pollution level is greater than the standard.

• Eight years of evidence-based, comprehensive tobacco prevention and education programs in the state have resulted in significant reductions in cigarette smoking in our state. The state's strong Clean Indoor Act is also protecting people with asthma from exposure to second-hand tobacco smoke in public places.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	88.1	88.1	86.4	89.0	89.0
Numerator	5421	5421	5761	6143	6143
Denominator	6154	6154	6666	6899	6899
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2008 CMS EPSDT Annual Report. Retrieved on 6/17/10 from http://www.cms.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp#TopOfPage .

Notes - 2008
2008 CMS EPSDT Annual Report. Retrieved on 6/17/10 from http://www.cms.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp#TopOfPage .

Notes - 2007
CMS Annual EPSDT Participation Report, 2007.

Narrative:
Developmental delay refers to when a child's development lags behind established normal ranges for his or her age. Sometimes the term is used for mental retardation, which is not a delay in development but rather a permanent limitation. If most children crawl by eight months of age and walk by the middle of the second year, then a child five or six months behind schedule in reaching these milestones may be classified as developmentally delayed regarding mobility. Some children have global delays, which means they lag in all developmental areas (Developmental Delay, n.d.). Developmental Delays differ from other types of learning disabilities in that they may improve with intervention and may eventually disappear. For that reason, it is important to be aware of early signs of a problem. Developmental Delays can exist in one or more of the following: cognitive skills; communication; social skills and emotional skills functioning; behavior; and fine and gross motor skills. According to the 2005/2006 National

Children with Special Health Care Needs Survey 5% of children/youth (0-17 years) have special needs that include ongoing emotional, behavioral or developmental issues in Delaware. Nationally, 4% of children/youth have special needs that include ongoing emotional, behavioral or developmental issues. In 2006, 908 children aged 0-3 years received early intervention services in accordance with Part C in Delaware. Fifty nine percent (59%) were white, 28% were black, 11% were Hispanic, 2% were asian or pacific islander and .1% were american Indian or alaska native. Children 2-3 years of age (> 24 to < 36 months) accounted for 55% of the children receiving services while 12% were birth to 1 year of age (0 to < 12 months) and 32% were 1 to 2 years of age (> 12 to < 24 months). Sixty two percent (62%) of children receiving services were female and 38% were male (Birth to 3 Annual Report, 2007).

Nationally, 3-7% of children suffer from Attention Deficit Hyperactivity Disorder (ADHD). According to the 2005/2006 National CSHCN Survey 29.8% of children with special health care needs have been diagnosed with ADHD nationally. In Delaware, 39.2% of children with special healthcare needs were diagnosed with ADHD.

National measures regarding developmental delay issues include the Healthy People 2010 leading health indicators: 16-14, Reduce the occurrence of developmental disabilities. Programs in Delaware include:

• Birth to Three is a statewide, comprehensive, coordinated, multidisciplinary, interagency system that provides early intervention services and supports for infants and toddlers with disabilities and developmental delays and their families.

• Child Development Watch is the statewide early intervention program for children ages birth to 3. The program's mission is to enhance the development of infants and toddlers with disabilities or developmental delays and to enhance the capacity of their families to meet the needs of their young children.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator					
Numerator	0	0	0	0	0
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final

Notes - 2009
All infants are eligible for Medicaid and therefore do not get SCHIP.

Notes - 2008
All infants are eligible for Medicaid and therefore do not get SCHIP.

Notes - 2007
All infants are eligible for Medicaid and therefore do not get SCHIP.

Narrative:
Children less than one year of age are not enrolled in SCHIP in Delaware. Infants are served by Medicaid.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	80.6	71.3	68.4	68.4	68.4
Numerator	9150	8450	8256	8256	8256
Denominator	11358	11857	12069	12069	12069
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data are not available at this time.

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 Vital Statistics data.

Narrative:
After increasing steadily through the 1990s and leveling off from 1998-2002 to 2001-2005, first trimester prenatal care attainment in Delaware decreased for the third consecutive time period, from 84 percent to 78 percent in 2003-2007. Since 2001-2005, each of the three counties and Wilmington experienced decreases in the
percentage of mothers receiving prenatal care attainment in the first trimester, though in Sussex county the decline had begun in 1998-2002. In 2003-2007, prenatal care attainment in the first trimester ranged from 63.4
percent in Sussex county to 84.5 percent in New Castle.

New Castle county had the highest rates of women receiving prenatal care in the first trimester, regardless of race (84.5%); Not including Wilmington with the balance of New Castle County produced similar results (85.9%). With the exception of Sussex county, black mothers and mothers of Hispanic origin received similar percentages of prenatal care in the first trimester (range 60.1% to 78.7%). Not only did Sussex County have the lowest percentage of mothers receiving prenatal care in the first trimester (63.4%), but it also had the greatest difference between Hispanic mothers and white and black mothers (27.1% vs. 64.2%, respectively).

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	94.8	93.8	94.2	94.3	91.2
Numerator	78004	81133	89704	94332	96861
Denominator	82292	86503	95253	100015	106259
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Division of Medicaid and Medical Assistance

Narrative:
The percent of potentially Medicaid-eligible children who have received a service paid by Delaware's Medicaid Program is reported in Table 7A. Due to econcomic conditions in 2009, the number of clients receiving a service has increased. The overall percentage, though reported as a decrease, may not accurately reflect the situation. The methodology to produce the denominator has changed from year-to-year over the past several years. The vast majority of Delaware's Medicaid Clients are enrolled in MCOs, however a portion still receive fee for service reimbursement or pharmacy-only reimbursement. These populations have not been included in some previous year's reporting.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	42.8	45.4	33.4	49.8	49.8
Numerator	6743	7472	5684	8880	8880
Denominator	15756	16474	16996	17817	17817
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data are provisional at this time and based on 2008 data.

Notes - 2008
2008 Annual EPSDT Participation Report.

Notes - 2007
CMS Annual EPSDT Participation Report, 2007

Narrative:
The Delaware Healthy Children Program is low-cost health insurance coverage for children in low-income families, costing between $10 and $25 a month regardless of the size of the family. It covers doctor visits, hospital stays, prescriptions, dental, glasses and more.

DHCP, which is also called the State Children's Health Insurance Program or SCHIP, is run by Delaware Health and Social Services, but the Insurance Commissioner's Office is currently working to help enroll more children in the DHCP.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	3334	3334	2927	3486	3486
Denominator	3334	3334	2927	3486	3486
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
SSI Annual Statistical Report, 2008

Narrative:
Delaware's Family 2 Family Program (F2F) partnered with the Healthy Delawareans with Disabilities Project and AI DuPont Hospital's transition coordinator on a series of workshops for parents and youth on healthy transitions. F2F trained the parents and the transition coordinator trained the youth simultaneously. F2F trained the parents of the transition timeline and what should be done to prepare the youth, from switching doctors, to guardianship issues and rights and special needs trusts. The trainings also explained the changes in Medicaid and SSI eligibility. Parents were provided with community resources and agencies to explore opportunities after their child leaves the school system. This training is being repeated and it will be held statewide.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight	2007	payment source	10.5	8.2	9.2

(< 2,500 grams)		from birth certificate			

Narrative:
A recent evaluation of the Healty Women, Healthy Babies Program (formerly Family Practice Team Model) revealed that out of 1,693 infant deliveries studied since the program's inception in 2008, 26 were very low birth weight, 124 were low birth weight (9% of births). This rate of low birth weight infants is lower than the statewide rate of low birthweight infants receiving Medicaid coverage.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2006	payment source from birth certificate	9.5	7.7	8.5

Notes - 2011
Data are from the five year period, 2002-2006.

Narrative:
Nationally, the infant mortality rate has remained level since 2000 at 6.86 deaths per 1,000 live births (2000-2005 average). As the rate has remained relatively stable, the disparity ratio has also been consistently high. Non-Hispanic black women are almost two and a half times more likely to experience an infant death compared with non-Hispanic white women (disparity ratio = 2.4).

In Delaware, the infant mortality rate continued to increase in the early 2000s to level at 8.8 deaths per 1,000 live births in the 2002-2006 time period. Like the U.S. disparity ratio, Delaware's infant mortality disparity ratio has remained consistently high with black women two and a half times more likely to experience an infant death compared with white women (disparity ratio = 2.5; 2002-2006). Additionally, both the infant mortality rate and disparity ratios vary by county. Kent County has the highest infant mortality rate, while Sussex County has the highest disparity ratio.

Intervention programs in Delaware specifically aimed at reducing infant mortality include the Healthy Women, Healthy Babies program. The program, initiated in 2007, focuses on women who are members of minority groups, reside in zip codes with high numbers of infant deaths, are underinsured or uninsured, have experienced a previous poor birth outcome such as low birth weight or premature delivery, fetal death, stillbirth, or infant death, and who are coping with chronic diseases. Also, the Smart Start program is a prenatal program that traditionally has focused on prenatal care for underserved populations throughout the state.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-**	**ALL**

system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State				**MEDICAID**	
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	payment source from birth certificate	57.1	75.4	66.9

Narrative:
The Family Practice Team Model and the Preceonception Care Program are now integrated into the Healthy Women, Healthy Babies Program. Other programs with a strong prenatal focus in the State include the Nurse Family Partnership through Children and Families First and Smart Start through the Division of Public Health.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	payment source from birth certificate	60.1	75.6	68.4

Narrative:
The Family Practice Team Model and the Preceonception Care Program are now integrated into the Healthy Women, Healthy Babies Program. Other programs with a strong prenatal focus in the State include the Nurse Family Partnership through Children and Families First and Smart Start through the Division of Public Health.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)		

Notes - 2011

Infants are not eligible. Infants receive Medicaid.

Narrative:
The percent of poverty level for eligibility in the State's Medicaid program for infants are reported in Table 6A. In Delaware the SCHIP program eligibility begins at 1 year of age. Infants are served through Medicaid.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2009	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2009	 200

Narrative:
The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for children are reported in Table 6B.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women		

Notes - 2011
Pregnant women receive Medicaid.

Narrative:
The percent of poverty level for eligibility in the State's Medicaid program for pregnant women is reported in Table 6C. Pregnant women do not receive SCHIP.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
The SSDI program manager worked vigorously on building a relationship with the Health Statistics Center who houses the birth cohort file, birth certificates, infant death records and fetal death records. The Health Statistics Center now sends the SSDI program the birth cohort file (linked birth certificates and infant death file) and the fetal death files once the data has been validated and cleaned. The 1989-2006 birth cohort file was received this past May which is the most current file available.

The SSDI program coordinated efforts with the Center for Family Health Research and Epidemiology to create the Registry for Improved Birth Outcomes. The Registry is a list of all women who had a poor birth outcome (premature, low birth weight or infant death). The Registry was created using 1989-2004, 1989-2005 and the most recent data 1989-2006. It contains information on the risks that women with more than one poor outcome face in Delaware. Between 1989 and 2006, 24,214 women experienced at least one poor birth outcome in Delaware. Of 24,214 women, 2,524 women experienced a second poor birth outcome (after removing multiples). The table below shows the percentage of first and second poor outcomes

for the 2,524 women who experienced a second poor birth outcome.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2011

Narrative:
In 2009, the adult smoking rate reached an all-time low of 17.8% and the high school smoking rate plunged to its lowest rate of 17.3%. More than 3,500 adult Delawareans enrolled in cessation counseling services: 2,346 chose Quitline (telephone); 1,773 chose face-to-face counseling; and 1,211 enrolled in Delaware Quitnet (web-based). The Tobacco Prevention Program awarded 31 community grants that will engage more than 11,500 youth and 6,200 adults in tobacco prevention activities.

IV. Priorities, Performance and Program Activities

A. Background and Overview

In the 2010 MCH Block Grant application, Delaware revisited its State Performance Measures based on the early stages of the Five Year Needs Assessment process. With this application, which incoporates the seven original performance measures reported in July 2010, three new state performance measures have been added. Two of these performance measures were included in revisions to the 2010 MCH Application submitted in September 2009 as result of recommendations from the Federal-State Partnership Review. One of the measures is related to to developmental disabilites and the second tracks benchmarks completed for the implementation of the statewide Family Support Initiative for Children with Special Health Care Needs.

Since September, the State has recognized the need for a broad measure to gauge progress on issues related to Children with Speical Health Care Needs. It was decided to track disparities among Children with Special Needs along a number of domains. Based on findings from the 2007 National Survey on Children's Health (NSCH), a number of key disparities have been identified for Children with Special Health Care Needs (CSHCN) when compared to their peers without special needs. These disparities are most pronounced in four key areas: Child Health Indicators; Emotional and Mental Health Indicators; Health Care Access and Quality Indicators; and Family Health Indicators.

According to the 2007 NSCH:

Disparities in Child Health Indicators

• General Health. Among those aged 0-17 years in Delaware, 71% (CI 65.1-76.9) of Children with Special Health Care Needs (CSHCN) were reported to be in overall excellent or very good health. This compared to 88.7% (CI 86.4-91.0) of non-CSHCN.

• Oral Health. Among those aged 1-17 years in Delaware, 64.1% (CI 57.8-70.4) of CSHCN were reported to have teeth that were in excellent or very good condition. This compared to 75.2% (CI 72.0-78.4) of non-CSHCN. In this same age rage, although not statistically significant, 15.2% of CSHCN were reported to have two or more oral health problems in the past six months. This compared to 8.1% of non-CSHCN.

Disparities in Emotional and Mental Health

• Parental Concern. Among those aged 4 months to 5 years in Delaware, 58% (CI 42.3-73.7) of parents of CSHCN reported concern over their child's physical, behavioral or social development. This compared to 36.4% (CI 30.9-41.9) of parents of non-CSHCN.

• At-Risk Children. Among those aged 4 months to 5 years in Delaware, 28.5% (CI 11.9-45.1) of CSHCN were reported to be at high risk for developmental, behavioral, or social delay. This compared to 7.2% (CI 4.2-10.3) of non-CSHCN.

• Social Behaviors. Among those aged 6 -- 17 years in Delaware, 81.1% (CI 74.6-87.7) of CSHCN were reported to consistently exhibit positive social behaviors. This compared to 94.6% (CI 92.4-96.8) of non-CSHCN. Furthermore, among this same age cohort, 24.8% (CI 17.8-31.8) of CSHCN were reported to often exhibit problematic social behaviors. This compared to 4.5% (CI 2.8-6.3) of non-CSHCN.

Disparities in Health Care Access and Quality

• Continuous and Coordinated Health Care. Among those aged 0-17 in Delaware, 48.4% (CI 42.0-54.8) of CSHCN were reported to have a medical home that provided continuous,

coordinated, comprehensive, family-centered and compassionate health care services. This compared to 63.6% (CI 60.3-67.0) of non-CSHCN.

• Effective Care Coordination. Among children needing care coordination in the past year, 52.1% (CI 44.6-59.7) of CSHCN were reported to receive effective care coordination. This compared to 79.3 (CI 74.9-83.7) of non-CSHCN.

• Specialist Care. Among children who needed specialist care in the past year, 14.2% (8.9-19.5) of CSHCN were reported to have had problems getting specialist care. This compared to 3.9% (CI 2.5-5.2) of non-CSHCN.

Disparities in Family Health

• Mother's Health. Among children in Delaware that lived with their mother, 53.9% (CI 47.3-60.4) of mothers of CSHCN were reported to be in very good or excellent general health. This compared to 66.6% (CI 63.2-70) of mothers of non-CSHCN.

• Mother's Mental/Emotional Health. Among children in Delaware that lived with their mother, 63.2% (CI 56.6 -- 69.8) of mothers of CSHCN were reported to have very good or excellent mental or emotional health. This compared to 75.4% (CI 72.3-78.5) of mothers of non-CSHCN.

• Fathers Mental/Emotional Health. Among children in Delaware that lived with their father, 71.4% (CI 64.7-78.2) of fathers of CSHCN were reported to have very good or excellent mental or emotional health. This compared to 82.2 (CI 79.2-85.1) of fathers of non-CSHCN.

B. State Priorities

The States Priorities are as follows:

Infant Mortality

Infant Mortality is a top priority in Delaware since the Infant Mortality Rate (IMR) is consistency higher than the U.S. average. In 2005, the Governor convened an Infant Mortality Task Force (IMTF) to make recommendations for reducing infant deaths in Delaware. The task force put together list of 20 recommendations. The task force developed into the DHMIC. The Consortium united with the DPH to establish infant mortality programs. Of the 20 recommendations, half were implemented over the following three years including targeted services for women during the preconception, prenatal, and postpartum periods. Additionally, research to explore the causes of infant mortality was undertaken through surveys and implementation of state surveillance systems. Through the combined effort of DHMIC and the DPH and support from the Governor's office and the Delaware Legislature, the DHMIC prenatal programs reached 20% of all Delaware pregnancies in 2008. Furthermore, Delaware's IMR decreased for the second consecutive period. From 2002-2006 to 2003-2007, IMR declined 3%, from 8.8 infant deaths per 1000 live births in 2002-2006 to 8.5 in 2003-2007.1 The rate is still too high especially when at looking at racial disparities. The data show a disparity in infant deaths among Black mothers compared to Caucasian mothers, with the largest disparity evident in Sussex County. At 16.9 deaths per 1,000 live births, the rate for Blacks in Sussex County is over three times as high as the rate for Caucasians, which stands at 5.0 per 1,000.

During the 2003-2007 period, the primary cause of infant death in Delaware was low birth weight and prematurity.1 The second leading cause of death, however, varied by racial group. For Black non-Hispanic women, sudden infant death syndrome (SIDS) was the second leading cause of death while birth defects were the second leading cause of death among White non-Hispanic women.

Low Birth Weight Infants/Preterm Birth

Infant low birth weight is a major predictor of infant mortality. Low birth weight babies are more likely than normal weight babies to have health problems during the newborn period. Low birth weight babies may also suffer from Respiratory Distress Syndrome and require additional oxygen and mechanical ventilation to breathe until their lungs mature. Other problems common in low birth weight infants include neurological problems, weakened immune system, and difficulty regulating body temperature, eating and gaining weight. In addition, low birth weight infants are at risk for experiencing Sudden Infant Death Syndrome.

Delaware has the eighth worst infant low birth weight percentage in the nation.7 The percentage of low birth weight infants born in Delaware continued to increase in the early 2000s to 9.28% in the 2003-2007 period.1

Preterm birth is the leading cause of infant mortality and morbidity in the United States. Preterm-related deaths account for more than one-third of all infant deaths, and more infants die from preterm-related causes than any other cause. Proper birth spacing is found to be a factor in preterm birth and a maternal health indicator. Health professionals' consensus is that minimum birth intervals of two years are important for infant, child and maternal health.12 Interpregnancy intervals (IPIs) of less than 6 or 12 months are associated with an increased risk of preterm birth. A meta-analysis of 67 studies showed IPIs shorter than 6 months were associated with increased risks of preterm birth, low birth weight deliveries, and small-for-gestational age (SGA) infants compared with interpregnancy intervals of 18 to 23 months.

Child/Teen Obesity and Overweight

A child's weight status is determined based on an age- and sex-specific percentile for BMI rather than by the BMI categories used for adults. Classifications of overweight and obesity for children and adolescents are age and sex specific because children's body compositions vary as they age and vary between boys and girls. The definition for being overweight or obese is:

- Overweight is defined as a BMI at or above the 85th percentile and lower than the 95th percentile.
- Obesity is defined as a BMI at or above the 95th percentile for children of the same age and sex.

The 2007 NSCH data indicated that for children ages 10-17 years nationwide, 32% are overweight (between the 85th and 95th percentile BMI-for-age) or obese (at or above the 95th percentile BMI-for-age).52 The 2007 NSCH reported that 35% of male children ages 10-17 years nationwide were overweight or obese compared to 27% of female children ages 10-17 years nationwide.52 For NSCH, 33% of children ages 10-17 years in Delaware were overweight or obese in 2007.52 According to the 2007 NSCH, 34% of male children ages 10-17 years in Delaware were overweight or obese compared to 32% of female children.52

The link between early childhood and the onset of childhood obesity has been identified as a growing concern in Delaware. In collaboration with the Health Promotion and Disease Prevention Section, the Title V MCH Program provided start-up funds for the development of a childhood obesity curriculum, "Healthy Habits - Healthy Start." The goal of "Healthy Habits, Healthy Start" is to train childcare providers in Delaware in how to use tools to increase physical activity and healthy eating of the children in their care while keeping in mind current childcare regulations. The tools in this training are the Sesame Street Healthy Habits for Life Resource Kit and Nemours Best Practices for Healthy Eating: A Guide to Help Children Grow Up Healthy. Under this project, the University of Delaware's Cooperative Extension, with input from Nemours Health and Prevention Services developed a curriculum consisting of 2 three hour sessions. Trainings commenced in January 2010 and have been offered on a monthly basis.

Obesity Among Women of Childbearing Age

Data from the National Health and Nutrition Examination Survey indicate that the prevalence of obesity among women has slightly increased over time from 33% in 2003-2004 to 35% in 2005-2006. The National Center for Health Statistics indicates that in 2006, 62% of all women over

age 20 were overweight. Black non-Hispanic women had the highest prevalence of obesity and overweight (80%), followed by Hispanic women (73%) and White non-Hispanic women (58%). The total cost of obesity and overweight in the U.S. in 2001 was $117 billion, $61 billion in direct cost, and $56 billion in indirect costs. Delaware BRFSS data indicate that 63% of residents between ages 18 and 64 are overweight or obese. Twenty-three percent (23%) of adult women in Delaware are considered obese.

Specific demographic characteristics are associated with obesity and overweight such as increasing age, race, childhood poverty, less education, and marital status. Health conditions causing obesity and overweight include food cravings, hormone changes, pregnancy, depression or anxiety, physical inactivity, stress, stressful life events, personality disorders, lifetime tobacco use, self-rated health, and body image. Weight gain among woman was more likely to contribute to a poor health self-rating compared with women who do not gain weight. Chronic conditions associated with obesity and overweight include hypertension, diabetes, and other metabolic disorders.

Unintentional Injury and Mortality among Children and Youth
The term covers a wide variety of incidents that occur from intentional and unintentional events which result in injury or death. Injuries can result from such things as motor vehicle accidents, falls, choking, firearms, fires, poisoning, athletic events, to name a few. Injuries may be severe enough to cause death. Once children reach the age of five years, unintentional injuries are the biggest threat to their survival. Risk for injury death varied by race. Injury death rates were highest for American Indian and Alaska Natives and were lowest for Asian or Pacific Islanders. Overall death rates for Whites and Blacks were approximately the same.

In Delaware in the 2003-2007 period, unintentional injuries comprised 18.43% of the deaths for children between ages 1-19 years.1 Moreover, in the 2003-2007 period, unintentional injuries were the leading cause of mortality representing 29.3% of deaths (17 of 58 deaths) for ages 1-4 years, 26.1% of deaths (18 of 69 deaths) for ages 5-14 years, and 55.3% of deaths (105 of 190 deaths) for ages 15-19 years.

Teen Smoking
Teen tobacco use includes smoking (cigarettes, cigars) and the use of smokeless tobacco. Most adults addicted to tobacco in the United States started smoking during adolescence, and without intervention, most current teenage smokers can be expected to continue smoking into adulthood.

The 2009 Delaware YRBS reported that 47.7% of students tried cigarette smoking at one point in their life, 19.0% smoked cigarettes on one or more of the past 30 days, 11.9% smoked at least one cigarette every day for 30 days, and 6.8% used chewing tobacco, snuff, or dip on one or more of the past 30 days.53 These results parallel nationwide rates (50.3% of students nationwide tried cigarette smoking at one point in their life, 20.0% smoked cigarettes on one or more of the past 30 days, and 7.9% used chewing tobacco, snuff, or dip on one or more of the past 30 days using 2007 U.S. YRBS data).55 Overall, 23.2% of Delaware students have used tobacco in some manner at least one in the past 30 days.53 In addition, 13.7% (13.8% of males and 13.2% of females) had smoked a whole cigarette for the first time before age 13 years.53 Among students who reported current cigarette use, 47.4% (43.8% of males and 51.4% of females) tried to quit smoking cigarettes during the past 12 months.53

Family Support of Children and Youth with Special Health Care Needs
Family support of children and youth with special health care needs (CYSHCN) is a multi-faceted approached to ensure parents, siblings and extended family have the resources, information, social support through informed networks and emotional support to care for a child with special needs. Family support must be family-centered -- it must meet them where they are and provide what they need in a culturally and linguistically appropriate manner. Since it is a diverse service and a one size fits all approach will fail, DPH MCH program has undertaken a year long stakeholder-led initiative to determine the needs and approach to better meet the diverse support

needs of families. The result is the development of an umbrella organization, called the Family Support Initiative, which has been described extensively in other sections of the narrative.

Developmental Delay
Developmental delays differ from other types of learning disabilities in that they may improve with intervention and may eventually disappear. For that reason, it is important to be aware of early signs of a problem. Developmental delays can exist in one or more of the following: behavior; cognitive skills; communication; emotional skills; fine and gross motor skills; and social skills.

Disparities among Families of Children and Youth with Special Health Care Needs
Disparities among families with CYSHCN are becoming increasingly evident every year. Research shows that a number of key disparities have been identified for Children with Special Health Care Needs (CSHCN) when compared to their peers without special needs. These disparities are most pronounced in four key areas: Child Health Indicators; Emotional and Mental Health Indicators; Health Care Access and Quality Indicators; and Family Health Indicators.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	12293	22	35	33	48
Denominator	12293	22	35	33	48
Data Source				Newborn Screening Data	Newborn Screening Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments
In 2009, the Division of Public Health's Newborn Metabolic Screening Program completed analyses of over 12,000 initial and repeat specimens. The program screens for 37 disorders including amino acidopthies, organic acidurias, fatty oxidation disorders, hemoglobinopathies and endocrinopathies.

Staff from the Newborn Metabolic Screening Program continued to provide follow-up services when inital screens were not completed at the birthing facility and for confirmatory (second) screens. When initial or confirmatory screens are not completed at a hospital or testing center, referrals are made to Public Health Nursing for a home visit.

The Newborn Metabolic Screening program continued to provide quiality assurance visits at birthing facilities and hospitals and to provide educational presentations to medical professionals throughout the State.

The program also is responsible for the administration of the Specialty Formula Fund in Delaware. This fund provides specialty formula to infants in need.

In addition to the on-gaoing administration of the Newborn Metaobolic Screening Program, additional activities included planning a web-based module for the Newborn Screening Data System. This module allows medical professionals to access newborn screening results over the internet on a 24-hour/7 day per week basis.

In 2009, Delaware increased its fees for Newborn Screening. The additional revenues from the increase (from $78 per infant to $98 per specimen) are designated for a new MSMS machine.

Newborn screening staff also worked with the MCH Director to determine the feasibility of using the Newborn Screening Data System as a core system for the development of an integrated child heath data system. During the year, plans were finalized to use the system for an enhanced birth defects registry.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Newborn Screening Program			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The view only web-based module for the Newborn Screening Data System was piloted at several pediatric sites throughout the state. During summer 2010, the module will be taken to scale statewide. A next step will involve the addition of remote data input for the system. This addition is scheduled to be completed by Fall 2010.

The Newborn Screening Program's Advisory Board is currently considering the addition of Severe Combined Immunodeficiency Disease (SCID) to the core panel of conditions screened for through Delaware's Newborn Metabolic Screening Program. The addition of this condition would make Delaware's core panel of conditions inclusive of all 29 conditions recommended by the federal Department of Health and Human Services as recently announced by Secretary Sebelius.

c. Plan for the Coming Year
A main focus of the Newborn Metabolic Screening in the coming year will be to develop a plan for a newborn screening (metabolic and hearing) long-term follow-up program. The Newborn Metabolic and Hearing Screening programs are moving to a web-based version of their current case management system and over the next year phased implementation will occur. Currently, the program is giving providers access to view metabolic and hearing results. Next year, with the new web-based case management application audiologists will be able to enter their diagnosis directly into the system as well as view early intervention services.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**12153**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	12153	100.0	12	0	0	
Congenital Hypothyroidism (Classical)	12153	100.0	5	3	3	100.0
Galactosemia (Classical)	12153	100.0	2	1	1	100.0
Sickle Cell Disease	12153	100.0	8	6	6	100.0
Tyrosinemia Type I	12153	100.0	5	5	5	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	65	65	65	65
Annual Indicator	56.9	56.9	61.1	61.1	61.1
Numerator					
Denominator					
Data Source				National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	65	65	65	65

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
The CYSHCN program within MCH identified the need for enhanced coordination within organizations that serve CYSHCN families. Organizations serving CYSHCN range from large, well-funded non-profit organizations to small volunteer-led entities. Most of these entities or groups have a disease/condition specific focus yet often share similar system-oriented concerns and struggle to identify resources. Recognizing this, CYSHCN conducted an assessment process to clearly identify shared concerns and unique interests of these Delawarean groups. The process was designed to promote consensus and greater understanding between groups of barriers and opportunities for cooperation. Two group meetings were held following a series of key informant interviews of stakeholders. Based on feedback from the interviews and information gleaned from interviews of states with best-practice CYSHCN coordination, the Bureau proposed the establishment of an "umbrella" organization that will serve as a fiduciary agent and single point of entry for family information and referral.

The following is a list of main themes that emerged in this process:

Fragmentation
- multiple funding streams
- lack of coordination among State agencies

Duplication of effort at the community organization level
- disconnect between agency mission and scope
- the need for authentic connection between agency and family vs. "passing off" families to others
- organizations knowing what each other does
- appropriate referral patterns

Case Management/Care Coordination
- need to identify which organizations do this or can do this
- parents as coordinators

With respect to Family to Family (F2F), last year's activities were: 1) established the F2F in Delaware by this was achieved by many presentations to providers and parent groups about F2F; 2) provided 7 trainings to families and professionals (impacted 200 persons); 3) conducted outreach to partners and communities 4) advocated for positive changes in service systems through extensive participation on advisory and related committees and councils; and 5) provided one to one support to 49 families. F2F is represented on almost all relevant councils and committees in Delaware, providing ""family" voice for families and change.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Newborn Screeing Program	X	X	X	
2. Child Development Watch	X	X	X	
3. Oral Health Program	X	X		
4. Primary Care and Physical Therapy, Occupational Therapy and Speech	X	X		
5. Respite Care	X	X		
6. Office of Children with Special Health Care Needs				X
7. Autism Registry				X
8. Birth To Three Early Intervention Coordinator, State Interagency Coordinating Council, Delaware Coordinating Council for Children with Disabilities				X
9. CSHCN Survey				X
10. Family Support Initiative				X

b. Current Activities

Success in this performance measurement is fueled by increased parent leadership and increased provider willingness and skill in engaging families in decision-making. Delaware depends on the CDC CYSHCN survey to gage efforts to increase engagement and satisfaction with that engagement. Delaware has focused this year on the aspect of parent leadership. As was reported in last year's Block Grant narrative, Family to Family (F2F) is not its own 501 (c) 3 non-organization. It is co-located with the University of Delaware under the Center for Disability Studies which serves as the fiduciary agent. Delaware invested approximately $50,000 in F2F for federal FYs 09 and 10 which served to help leverage $95,700 of HRSA funding in FY09. Family to Family was tasked this current year to increase parent leadership in CYSHCN activities. In this reporting period, F2F encountered problematic administrative challenges in the start-up of their new arrangement with University of Delaware. The Bureau draws attention to these F2F deliverables in this period: a three part series on transition planning which had youth and parent breakout groups -- leadership skill-building comprised a portion of the adult and youth sessions. A series of sessions was held in each of Delaware's three counties.

c. Plan for the Coming Year

The Bureau plans to press forward with a three-pronged approach.

The first prong is to continue to challenge and encourage F2F to maximize its impact. F2F will be asked to meet some discrete goals including conduct of effective activities in Sussex and Kent Counties, rural areas of Delaware. Specifically, and in partnership with the Family Support Initiative, build on the three transition workshops to establish a formal Transition Plan for Delaware and establish the toll-free line and web presence for the Family Support Initiative.

The second prong will be that FSI will undertake activities identified by participating organizations to address the major work components of their contract. CDS will be expected, at a minimum, to

address performance through these systems-level and targeted organizational-level actions:

1) Increase efficiency of the systems serving children, youth and young adults with special health care needs by:
a. Reducing fragmentation and duplication
b. Enhancing collaboration

2) Care coordination

3) Capacity-building of organizations, parents, youth and young adults through assessment and coordinated training. Assessment of organizations within the umbrella should include, at a minimum, the following:
a. Governance
b. Sustainability
c. Strategic Planning
d. Evaluation - It is expected that the Umbrella Organization will work with partner organizations to complete an organizational assessment and a strategic
plan.

4) Provide information and referral services that reflect the complex information needs of families.

The strategy of using the umbrella organization, known as FSI currently, will also be used to achieve many of the Federal and state performance measures in this Report. FSI will also play a critical role through-out the five year life cycle of the MCH Needs Assessment process.

The third prong is to replicate portions of the CDC CYSHCN survey in Delaware using a mixed-methods approach in the intervals between the telephone survey so as to acquire more timely feedback on system performance and family perceptions of services. This survey is expected to be launched in Fall 2010; CDC's lead for the survey has expressed intellectual support for this survey and is available for technical assistance, but has no funds available to invest in the process. This survey will be one of the components of The Bureau's evaluation strategy.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55	60	60	50	50
Annual Indicator	52.8	52.8	48.1	48.1	48.1
Numerator					
Denominator					
Data Source				National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over					

the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	50	50	50	50

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
The main focus of this performance measure is "medical home." Several strategies were deployed last year to move toward achievement of this national performance measure. They were: one, the passage of legislation to support appropriate screening, the first step leading to a comprehensive care plan; two, critically vital efforts by the Delaware Chapter of the American Academy of Pediatrics (AAP) to support developmental screening; three, the funding of Family To Family to perform advocacy and systems change work; and, four, the convening of CYSHCN providers in order to form an umbrella organization, a step needed to move toward having a power base sufficient to influence system change efforts such as the promotion of medical homes.

With respect to developmental screening, HB 199 Developmental Screening of Infant and Toddlers passed last year. This Act requires that private health insurers in Delaware cover the developmental screenings for infants and toddlers that are recommended by the American Academy of Pediatrics and the Delaware Early Childhood Council. Such screenings are already covered for children in the State's Medicaid program. The estimated cost to policy holders of covering these screenings is three cents per member per month.

With respect to the medical home concept, the Delaware Primary Care Physician Survey is conducted on a periodic basis. This survey is based on the "Center for Medical Home Improvement's Medical Home Questionnaire." The survey conducted in 2008 included a question used to track clinician awareness of the concept. The survey administered in 2008 determined 22.7% of physicians and 12.5% of pediatricians in Delaware reported no knowledge of medical home concept. Further, only 9% of physicians and 28.8 % of pediatricians indicated they were knowledgeable about the medical home concept and applied it that concept on a regular basis. Note that the Delaware Chapter of AAP conducted two educational sessions entitled "Keys to Practice Improvement" to promote the medical home concept.

With respect to advocacy and system change, the foundation for the current year's activities rests on the work done last period to assess and candidly discuss system fragmentation with CYSHCN providers and families. As related above relative to Federal performance measure #2, and as will

be related across all federal and state performance measures, this serious structural issue for Delaware's CYSHCN program will be addressed through the establishment of and effective operations of the umbrella organization, which is currently known as the Family Support Initiative (FSI) A critical part of establishment of this organization was the crafting of the RFP. The Bureau looked to Rhode Island and New Jersey as best practice models and sought out technical assistance from AMCHP resource staff. Also, the Bureau provides about one-third of the funds needed to operate Family To Family (F2F), the primary non-diagnose-specific family-led advocacy group for all CYSHCN in Delaware.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN Survey				X
2. ECCS Program/Health Resources Bureau				X
3. Transition of Care for CYSHCN				X
4. Office of Children with Special Health Care Needs				X
5. Autism Registry				X
6. State Interagency Coordinating Council, Delaware Coordinating Council for Children with Disabilities				X
7. Family Support Initiative				X
8.				
9.				
10.				

b. Current Activities

The Delaware Chapter AAP joined forces with the Family Health Section of the DE Division of Public Health to host a developmental screening symposium on April 28. Delaware's Developmental Comprehensive
Screening (DCS) project is funded by Blue Cross Blue Shield of Delaware. This one day event featured key political and medical leaders including the Lt Governor of Delaware and key note speaker, Anne B. Francis, MD, FAAP.

This period's activities have centered on both the letting of a contract to establish the FSI and a strategy to engage providers, including the education system, around the systems building challenge of mounting an autism registry. The Bureau is required by Delaware law to maintain an autism registry. Since its inception in 2005, providers have reported limited data. The Bureau is using this opportunity to coordinate with the American Academy of Pediatrics, specialists, major provider systems, and the Delaware Medical Society to provide updates on autism as well as the requirement by law to report a minimal number of data fields.

c. Plan for the Coming Year

FSI goals 1, 2 and 4 directly relate to the achievement of this performance measure. The FSI contract began on March 1, 2010. The contractor facilitating this effort, University of Delaware, Center for Disability Studies (UDS-CDS) formulated a work plan that had these essential elements:

- A group meeting of probable collaborators to launch effort and solicit public input into Needs Assessment
- Conduct a comprehensive environmental scan
- Facilitate a Collaborator's Summit
- Web and print (large print, Braille and audio) information resources
- Communication of emerging issues, opportunities

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	67	70	70	65	65
Annual Indicator	66.7	66.7	63.2	63.2	63.2
Numerator					
Denominator					
Data Source				National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	65	65	65	65

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
These two Bills received the support of the Bureau last year -- SB 65 and HB 22. SB 65 Requires private insurance payors to cover out of network dental care for children with special needs. Prior to the passage of this Bill, in-network dentists or orthodontists frequently did not serve children with special needs associated with behavior or physical impairments. The benefit of this Bill is that families can acquire needed care without the burden of out-of-pocket expenses. HB 22 served to extend CHIP coverage to families with incomes up to 300% of Federal Poverty Level (FPL). The level prior to passage of this Bill was 200% of FPL. The benefit of this Bill was elimination of financial barriers to access to care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN Survey				X
2. State Interagency Coordinating Council, Delaware Coordinating Council for Children with Disabilities				X
3. Office of Children with Special Health Care Needs				X
4. Family Support Initiative				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The plan for current year activities as reported in last year's Block Grant narrative was to establish the umbrella organization (FSI) and then, in partnership with F2F, pilot a family liaison program in one pediatric practice. . The pilot is now being actualized through the Parent Education Resource Center. The premise here is that at the point of diagnosis that families would receive guidance and support in accessing all available resources, including insurance -- thus the activity of the PERC directly supports this performance measure. The Parent Education Resource Center (PERC) is one of the primary goals of the Blue Cross Blue Shield Developmental Comprehensive Screening grant. The purpose is to engage the parent in the developmental screening process and provide educational and early intervention service resources. The program has a Parent Liaison-who oversees the operation of the PERC in each of the 4 pilot sites. Within each pilot site there is, at a minimum, one Parent Advocate.

c. Plan for the Coming Year

In addition to the work of the PERC, the Bureau intends to conduct a survey of families by web and pencil-and-paper that replicates sections of the CDC telephone survey. This mixed-methods survey will provide valuable data in between CDC-released findings. Questions on insurance status to the CYSHCN survey will be included; there is also the ability to ask families to report instances of not being able to acquire care due to lack or insurance -- separate and distinct from question of being unable to acquire care due to lack of providers. The Bureau will also reach out to Department of Insurance and/or Gov. Council on Exceptional Citizens to see how they are tracking/handling complaints form CYSHCN families as a second and possibly third source of data. The Family Support Initiative and its collaborating partners will also be tapped to develop methods of quantifying access to care, such what this performance measure address.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	75	80	80	90	90
Annual Indicator	72	72	88.1	88.1	88.1

Numerator					
Denominator					
Data Source				National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	92	92	92	92

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
The Bureau reported in last year's Block Grant narrative on this measure through Table4a that F2F would establish web-based information on resources for families. This was not accomplished and the goal has reassigned through the establishment of the Family Support Initiative (FSI), or "umbrella" as a system goal for Information and Referral.

As HRSA already knows, in most states the same organization that receives significant funding from Department of Education for the Parent Information Centers also is the "parent" or "home" for Family to Family, Family Voices and other parent led or parent resource organizations. In Delaware, these organizations have emerged separately. While diversity in sources of influence is a strength of this course of organizational development, it has also resulted in a "system" that is not as much of a coordinated "system" as it needs to be in order to best serve Delawarean families of CYSHCN. Some of the most compelling feedback obtained by the Bureau during the group consensus building process used last period to inform the crafting of the RFP for the FSI was a critical lack of understanding on the part of providers of the complexity of information needs of families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Support Initiative				X
2. Transition of Care for CYSHCN				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The contractor selected as the facilitator for the FSI, UDS-CDS, has as a principal goal, Goal #4, information and referral. See also State Performance Goal # 22. Beginning in mid-2010, FSI will canvass all provider and parent support groups in a systematic fashion to collect data needed to form a more comprehensive and effective information and referral system. FSI has engaged the Delaware PIC in a contract that is designed to foster increased linkages and support for building a better I&R system for Delaware.

The Bureau reported out in last year's Block Grant narrative that it intended "…to conduct a system wide evaluation of early intervention services for children and families. One of the goals of the assessment is to ensure services are community-based and easy to use (e.g., limited/no barriers to care). Services identified as difficult to navigate by families will be improved." The Bureau plans to achieve progress toward goal for this aspect of the performance measure through the planned replication of a part of the CDC CYSHCN survey in Delaware using a mixed methods approach in Fall of 2010. One of the logical bases for soliciting respondents will be the early intervention service providers.

c. Plan for the Coming Year
Goal #4 for FSI focuses directly on this performance measure. As such, FSI plans to conduct a comprehensive environmental scan, followed up by a Collaborator's Summit and strategic planning for the FSI.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	20	20	25	45	45
Annual Indicator	5.8	5.8	42.4	42.4	42.4
Numerator					
Denominator					
Data Source				National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	45	45	50	50	50

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
Last year the Bureau was able to report that the A.I. Du Pont Hospital for Children, the only children's hospital in Delaware had founded an Office of Transition. In this past year, Christiana Hospital followed suit an started an internal Transition Work Group facilitated by Dr. Louis Bartoshefsky, who also serves as the Medical Director for the Bureau.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Transition of Care for CYSHCN				
2. Family Support Initiative				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
This Federal Performance Measure has to do specifically with the experiences reported by youth during transition regarding their ability to receive the "…services necessary to make transitions…" The Family Support Initiative has been tasked with establishing a Transition Plan for the State; it is expected to be developed by the end of the two year contract period. Transition workshops were expanded from New Castle to Kent and Sussex Counties as a part of the Transition Plan Development work. The FSI convened a group of probably collaborators on May 5, 2010 and reviewed the federal and state performance measures. It also launched its overall effort and detailed specifics on the comprehensive environmental scan, Collaborator's Summit, the upcoming Fall mixed methods survey -- See State Performance Measure #10 (for the 2011-2015 time period).

c. Plan for the Coming Year
The Bureau is planning to include questions needed to establish performance on this measure as a part of its mixed-methods replication of portions of the CDC CYSHCN process it will be establishing in the Fall of 2010. This assessment activity will help inform the work of the Family Support Initiative.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	80	82
Annual Indicator	82.6	76	78.9	80.3	71.8
Numerator					
Denominator					
Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	74	76	78	80	82

Notes - 2009
National Immunization Survey, Selected Vaccination Series by 19-35 Months of Age, Delaware 4:3:1:3:3:1. Estimated Vaccination Coverage, 2008. Confidence interval for the estimate is +/- 6.8. Note that the CIs for the 2007-2008 Surveys overlap. There is not statistically significant difference for the 2008-2009 estimates.

Notes - 2008

National Immunization Survey, Selected Vaccination Series by 19-35 Months of Age, Delaware 4:3:1:3:3:1. Estimated Vaccination Coverage, 2007. Confidence interval for the estimate is +/- 5.7.

Notes - 2007
National Immunization Survey, Selected Vaccination Series by 24 Months of Age, Delaware 4:3:1:3:3. Estimated Vaccination Coverage (March 2006-February 2007). Confidence interval for the estimate is +/- 6.1%.

a. Last Year's Accomplishments
The Immunization Coalition of Delaware continued its work in promoting seasonal influenza vaccination, promotion of HPV vaccination for girls and young and promoting best practices for adolescent well visits as opportunities for booster vaccinations.

The Governor and Lt. Governor made a proclamation during Infant Immunization Week (April 2009), highlighting the importance of keeping children up to date with immunizations and the continuing risk for many diseases that people take for granted but that are actually "still out there".

CHILD HEALTH IMMUNIZATIONS -- The Hudson State Service Center's Child Health/Immunization Clinic continues to be the safety net for those who are uninsured, underinsured, and for those who are foreign born and new to the country. The child health staff has vaccine information sheets in 21 different languages to communicate effectively with non-English speaking clients. The importance of the service provided by the Hudson nursing staff cannot be overstated. Clients who will not go anywhere else will come to the Hudson Center for physicals and immunizations for their children because of its reputation as a "safe place." Also, staff communicate with non-English speaking clients and assist them with their needs. When the client cannot speak English, client visits can take up to two hours. Staff expertly deciphers foreign immunization records and communicates important health information to their clients.

H1N1 INFLUENZA CLINICS -- In response to the 2009 H1N1 influenza pandemic, the Office of Emergency Medical Systems (OEMS) addressed the need for mass vaccination of the EMS workforce. With assistance from paramedic agencies, OEMS staff conducted 15 H1N1 influenza vaccination clinics to ensure vaccine availability to the EMS priority group.

The Immunization Coalition of Delaware held a 5K Run/ Walk to publicize National Immmunization Awareness Month, August, 2009, in DE. Individuals and teams from healthcare sector competed for prizes in the run and immunization awareness was provided through "Facts" signs along the route as well as having nurses available post race to talk with individuals about immunization schedules for children and adults.

The Governor and Lt. Governor made a proclamation during Infant Immunization Month (April 2010), highlighting the importance of keeping children up to date with immunizations and following an appropriate schedule of vaccinations. In addition, the Coalition sponsored a different outreach each week, including a physician on talk radio answering questions, an outreach to women of child bearing age to get the Tdap prior to pregnancy to protect the future newborns and infants under six months of age, and a simultaneous Community Walk in five towns in Sussex County where immunization information was provided.

Throughout the H1N1 Flu season, the Coalition served as a communication group for H1N1 information dissemination, as well as feedback mechanism on how Delaware was doing with the distribution of H1N1 and seasonal flu vaccine. One meeting was devoted entirely to a presentation from a private physician's office on the challenges of vaccinating for flu, especially the new challenges with novel H1N1. This information was valuable in understanding the needs of physician practices in trying to meet the vaccination needs of their patients, inlcuding scheduling difficulties and lack of sufficient payment structure for vaccination and the education

compenent that goes with it.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Delaware Immunizations Coalition				X
2. Delaware Division of Public Health Clinics and Field Staff	X	X	X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
We are currently planning a Pertussis professional educational event, to highlight the need to get adults and adolescents vaccinated against pertussis and protect the under six months of age infants.

As every year, the Coalition will have a focus on Flu season planning with an effort this year of getting all ages vaccinated for seasonal flu. We coordinate among the providers to try to reach everyone and reduce duplication of effort in serving the public.

c. Plan for the Coming Year (2011
We plan to recognize one of our flu vaccination partners, the New Castle County Farmers Market owner and manager, who helped us to reach out to a wide audience of varied ethnic background for flu and H1N1 flu vaccination efforts last year, by providing space and advertising our flu shots. This location was larger than any single venue in reaching an important part of the population that may not have otherwise been able to receive the flu vaccines.

HVP vaccine for adolescents will be an important focus for this years activities.

c. Plan for the Coming Year
Continue working with partners to implement the Immunize Every Size message and promote childhood immunizations toward the goal of achieving 90% up-to-date status by age 2. This includes continuing education with parents and providers. The goal of Immunize Every Size is:
• All children have access to vaccines;
• Healthcare providers are aware of immunization standards of practice;
• The latest recommendations on vaccines are available to providers; and
• Providers and the public have access to up-to-date answers to vaccine questions.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2005	2006	2007	2008	2009

Performance Data					
Annual Performance Objective	28	27	26	20	20
Annual Indicator	22.2	22.0	22.0	22.0	22.0
Numerator	381	386	387	387	387
Denominator	17170	17572	17600	17600	17600
Data Source				Delaware Vital Statistics, 2007	Delaware Vital Statistics, 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	20	20	19	19	18

Notes - 2009
2009 data are not available. It is anticipated that 2009 data will become available in early 2012.

Notes - 2008
2008 data are not available. It is anticipated that 2008 data will become available in early 2011.

Notes - 2007
2007 Delaware Vital Stats

a. Last Year's Accomplishments
Title X is the federally supported and state supplemented family planning program. In 2009, there were 25,381 unduplicated clients who made 55,169 visits. Twenty-five percent (25%) of the clients served were between 12-19 years of age.

SCHOOL-BASED HEALTH CENTERS -- The enrollment in Delaware's 28 School-Based Health Centers increased. In 2009 SBWC enrolled 79.4% of the school population (34,327). Of the total 60,497 visits, 1,163 of them were pregnancy related. In addition, there were 1,393 pregnancy tests administered resulting in 120 positive pregnancies. It is unknown how many of the 120 pregnancies resulted in a live birth.

The Alliance for Adolescent Pregnancy Prevention continues providing evidence-based interventions to teens using three proven programs: Wise Guys, Making Proud Choices and Making a Difference. In FY 09, AAPP reached 485 teens.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Title X Family Planning	X	X		
2. Wise Guys		X		
3. Make Proud Choices		X		
4. School-Based Wellness Centers	X	X		

5. Infant Mortality Social Marketing (Reproductive Life Plan)		X		
6. Teen Pregnancy Advisory Board				X
7.				
8.				
9.				
10.				

b. Current Activities
DPH continues to reassess the reach of the Alliance for Adolescent Pregnancy Prevention (AAPP) programs. Given the limited amount of state funds for teen pregnancy prevention ($333.0 annually) it is important the funds be utilized to provide evidenced based programs and initiatives that reach those teen most at risk.

In December of2009, the Division of Public Health was notified that School-Based Wellness Centers (SBWC) were not in compliance with current Medicaid reimbursement regulations. During the course of discussions on Medicaid billing with the various SBWC stakeholders the issue of providing reproductive health services at SBWC was discussed. As a result DPH will re-look at the delivery of reproductive health services within SBWC. Although STD testing is provided in 75% of all centers, none provide contraception for routine pregnancy prevention. Although this issue is controversial, it merits a discussion with each school district to share the community specific epidemiologic data that supports delivery of full reproductive health services at each SBWC.

c. Plan for the Coming Year
Promote adolescent health, including mental health to help reduce high risk behaviors such as unprotected sex. Carry-out school district specific meetings with advisory boards and Parent Teacher Organizations to share community-level data about teen pregnancy, STDs and infant mortality. DPH will also include evidence that supports reproductive health services in SBWC as a means to reduce adolescent risk taking behavior by delaying initiation of sexual intercourse, reducing the frequency of partners, increasing condom use and other forms of contraception. DPH will begin the development of new consent forms including consents for reproductive health services for introduction into SBWC in FY 12.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	35	35	40	35	35
Annual Indicator	34	34	34	34	34
Numerator					
Denominator					
Data Source				Delaware Dental Survey	Delaware Dental Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be					

applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	35	35	37	37	39

Notes - 2009
The 2009 indicator is based on a 2002 statewide survey of third grade children. More recent estimates are not available at this time.

2010 Sealant Stats for the Oral Health Program:
# of Children Screened (2nd grade): 30
# of Children w/ Caries Presence (Decay): 18
# of Total Sealants Placed: 68
#Regular Referral: 15
#Urgent Referral: 5 (urgent is classified when pain or infection present within diagnosis of decay/ extraction)

Notes - 2008
The 2008 indicator is based on a 2002 statewide survey of third grade children. More recent estimates are not available at this time.

Notes - 2007
The 2007 indicator is based on a 2002 statewide survey of third grade children. More recent estimates are not available at this time.

a. Last Year's Accomplishments
The Bureau of Oral Health and Dental Services (BOHDS) received the long-awaited Dental Mobile Van. Delivered in December 2009, the mobile dental clinic is used to conduct the statewide Seal-A-Smile sealant program for Delaware's most at-risk elementary schools. Due to staff shortages in the BOHDS, the sealant program had been inactive for the past one to two years. However, a small pilot project of the sealant program reconvened on April 30, 2010 at the Woodbridge Elementary School in Sussex County. The van also conducted a program at the South Dover Elementary School in Kent County. Sealant program administrative staff vacancies still present a significant challenge for the program. Currently, state service center dental clinic staff have been operating the van on a limited basis. It is anticipated the van, when not in use for the sealant program, will be used to provide dental screening and services for pregnant mothers participating in Delaware's Healthy Women Healthy Babies DHMIC initiative and possibly other child serving systems (e.g. Head Start). The program administration of the van is still being confirmed for usage in the 2010-2011 years. A promising initiative with a Sussex County federally qualified healthcare center is being negotiated that will increase oral health care access and services for Delaware's most underserved area. Finally, the mobile dental clinic has also been used to conduct community outreach activities, including the Head Start Association's annual conference in March 2010.

2010 Sealant Stats:
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# of Total Sealants Placed: 68
#Regular Referral: 15
#Urgent Referral: 5 (urgent is classified when pain or infection present within diagnosis of decay/ extraction)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Oral Health Program	X	X	X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Delaware Oral health Coalition is focused on reducing the high level of dental disease among the state's children and early prevention and maintenance. Through local and national partnerships, the Coalition is developing an infrastructure to increase awareness about the importance of good oral health and its relationship to good overall health.

The DPH Maternal and Child Health program provides child oral health continuing education to non-dentist professionals who are engaged in health or day care of children and youth. The training is "Open Wide" developed by the National Maternal and Child Oral Health Resource Center (NMCOHRC). DPH MCH (through contract with Health Equity Associates) adapted the on-line program for in-person training. IT was offered in Sussex County to child care providers and received overwhelming response. Additional sessions are scheduled for fall 2010.

c. Plan for the Coming Year
Delaware intends to increase the Maternal and Child Health's participation in child dental health issues through collaborative partnerships and established committees and coalitions focused on improving oral health access.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	2.5	2.5	2.5	1.7	1.7
Annual Indicator	1.8	1.8	1.8	1.8	
Numerator	9	9	9	9	
Denominator	500732	500732	500732	500732	
Data Source				Hospital Discharge Data, 2005	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be					

applied.					
Is the Data Provisional or Final?				Provisional	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1.7	1.7	1.7	1.7	

Notes - 2009
2009 data are not available. It is anticipated that 2009 data will become available in early 2012.

Notes - 2008
Data are not available for 2008. It is anticipated that 2008 data will become available in early 2011.

a. Last Year's Accomplishments
In 2008, the Office of Highway Safety (OHS) worked on the following initiatives related to occupant safety in motor vehicles:

- Click it or Ticket Enforcement and Education Campaign
- Nighttime Seat Belt Enforcement Campaign
- Statewide Seat Belt Use Survey
- Teen Seat Belt Use Initiative
- Child Passenger Safety Awareness Week
- Child Passenger Safety Fitting Stations
- SAFETEA-LU Occupant Protection Incentive Grant Administration -- Sections 405 and 2011

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Emergency Medical Services for Children and the Injury Prevention Coalition continue to address motor vehicle related injuries and deaths among children as a priority area.				X
2. Smart Start, Kids Kare and Child Development Watch complete safety assessments at clinic and home visits.		X		
3. State Service Centers offer child safety seat loaners to parents who cannot affort to purchase one.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The contractor hired to assist the Bureau in absence of a CYSHCN Director interfaced with the OHS, Office of Emergency Services (OES) and the Delaware Injury Prevention Coalition (DIPC) to review and analyze data and best practices relating to this indicator. The Bureau also worked with Children's Safety Network for technical assistance. See also State Performance Measure # 20 which relates to injuries for children as a result of motor vehicle crashes.

c. Plan for the Coming Year
The Bureau renewed its participation in the Delaware Injury Prevention Coalition at the March 2010 meeting. The Director MCH presented a thorough analysis that the Bureau had performed

on DE OEMS trauma registry data. The group expressed interest in reduction of injury to youth aged 15-19, and MCH representation on the Coalition will continue to identify strategies to address injury prevention.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		12	36	36	32
Annual Indicator	10.6	35.7	30.6	30.6	32.8
Numerator					
Denominator					
Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	34	34	34	36	36

Notes - 2009
2006 National Immunization Survey (32.5% +/- 6.6%) - Any breastfeeding at 6 months of age.

Notes - 2008
2005 National Immunization Survey, CDC.

Notes - 2007
2005 National Immunization Survey, CDC.

a. Last Year's Accomplishments
In 2009, the Office of Rural Health and the MCH Program provided funding for a pilot project, "Breast is Best," designed as an enhancement to Smart Start and in addition to available WIC breastfeeding services. The project paid for lactation consultant training, purchased breastfeeding supplies and educational materials and supported a statewide conference for professionals. The Breast is Best Conference was held on June 11th at PolyTech Adult Education Conference Center in Woodside. Speakers included breastfeeding educator Vergie Hughes, RN, MS, IBCLC, FILCA; breastfeeding advocate Dr. Joseph DiSanto from Brandywine Pediatrics; and Division Director, Dr. Karyl Rattay. The event was attended by 118 health care professionals (including private medical providers, state employees and community partners). The conference evaluation data from the attendees were very positive and indicate success in meeting conference objectives.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Title V is supporting a program, "Best Smart - Breast is Best," an enhancement to the Smart Start program. The goal of the program is to have at least 80% of program participants breastfeeding their infants at 6 months of age.		X		X
2. In June, 2010, the Delaware MCH program sponsored the second annual statewide conference for medical professionals "Breast is Best." Over 150 professionals attended this full day educational opportunity.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

On June 9th, 2010 the Second Annual Breast is Best Conference was held at Polytech Adult Education. Approximately 137 clinicians attended the conference sponsored by the Office of Rural Health and the Office of Maternal Child Health. The Division of Public Health's Office of Nursing, and Southern Health Services were directly responsible for planning and coordinating the conference. The event addressed the significance of breastfeeding on the public's health and invited an international breastfeeding expert, Marsha Walker, who discussed specific strategies on improving the rates of breastfeeding including hospital based and "Ban the Bag" interventions. The conference was concluded by a local Wilmington-based Pediatrician Dr. Joseph DiSanto, who discussed the A.A.P.'s position on breastfeeding.

The pilot project (Best is Best enhancement to Smart Start) started in Kent and Sussex Counties was expanded to New Castle County.

c. Plan for the Coming Year

Conference evaluations for the first two Breast is Best Conferences were overwhelmingly positive, and planning activities will occur over the next year for a third annual conference.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	100	100	100	100	100
Annual Indicator	98.2	98.4	93.7	98.7	99.4
Numerator	12098	12147	11864	12468	12079
Denominator	12324	12342	12666	12627	12153
Data Source				Delaware Newborn Hearing Screening Program	Delaware Newborn Screening Program
Check this box if you cannot					

report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2007
The Newborn Hearing Screening program is currently reviewing 2007 information to ensure all records have been entered accurately into the data system. The data reported for 2007, therefore, is provisional at this time.

a. Last Year's Accomplishments
The Newborn Hearing Screening Program has worked diligently on implementing new guidelines for dual screening (Otoacustic Emission and Auditory Brainstem Response). Included in this implementation was a revamping of the reporting forms as well as the data system that house the screening data. Also, the Newborn Screening Program supported the purchase of a dual screener for the Birthing Center of Delaware.

The Newborn Hearing Screening program worked closely with the Delaware Chapter of Hands and Voices as the organization applied for its 501 c 3 tax exemption.

The Delaware Infant Hearing Assessment and Intervention Program Advisory Board has shifted its focus from merely increasing screening utilization to a more in depth planning and develop to ensure entry into early intervention services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Delaware Early Hearing Detection and Intervention program supports a Delaware Chapter of Hands and Voices.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Newborn Hearing Screening Program worked closely with the Delaware Chapter of Hands and Voices to implment the Guide by Your Side Program. Guide by Your Side assists families with navigation of the early intervention system.

The Delaware Infant Hearing Assessment and Intervention Program Advisory Board has shifted its focus from merely increasing screening utilization to a more in depth planning and develop to ensure entry into early intervention services. Guide by Your Side will play a crucial role in this

process.

The Newborn Hearing Screening Program has developed a protocol for tracking late on-set hearing loss among children through age 18.

The Program held the fourth annual "Delaware's Still Listening Conference" on March 18, 2010. Evaluations received from this event were very positive. The agenda included sessions for professionals and sessions for families of children with hearing loss.

The Program ran a statewide public service announcement on 5 cable television stations promoting newborn hearing screening and advertising the State's Hearing Aid Loaner Bank Program (a program that loans hearing aids and FM transmitters to children in families without adequate insurance or resources to purchase these items).

c. Plan for the Coming Year

Delaware plans to continue its efforts with the Delaware Chapter of Hands and Voices by establishing the Guide by Your Side Program. This program provides emotional support and unbiased information from trained Parent Guides (PG) to other families who are faced with making early intervention services decisions for their children who are diagnosed with hearing loss. GBYS will refine the program guidelines and implement this flexible program, which will meet the unique family support and outreach needs in Delaware by:

• Reducing the risk of loss to follow up by timely connection with a Parent Coordinator/Parent Guide to families with babies who do not pass the newborn hearing screening.
• Provide timely parent-to-parent support at the time of confirmation of hearing loss.
• Influence and improve systems designed to serve families and their children who are deaf or hard of hearing by providing a recognized role for GBYS Program Coordinator and/or Guides in early intervention programs and public education at the decision-making levels.
• Assure continuity to families by providing support throughout a child's life, especially at times of transitions; GBYS is not limited to a specific age range.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8.2	8	8	12	10
Annual Indicator	12.6	12.3	12.3	10.5	9.4
Numerator	25484	24992	24992		
Denominator	202255	203188	203188		
Data Source				Kids Count Fact Book, 2009	Kids Count Fact Book, 2009
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2010	2011	2012	2013	2014
Annual Performance Objective	9.2	9.2	9	9	8.8

Notes - 2009
This is a percent based on estimates from the Center for Applied Demography and Survey Research (Three year average 2007-2009).

Notes - 2008
This is a percent based on estimates from the Center for Applied Demography and Survey Research (Three year average 2006-2008).

Notes - 2007
Source: Delawareans Without Health Insurance, Univerisity of Delaware, 2006.

a. Last Year's Accomplishments
HB 22: Extended CHIP coverage to families with incomes up to 300% FPL. This increase (level was 200%) will allows families with higher income to qualify for the program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Community Health Access Program (CHAP) helps provide access to primary care doctors, medical specialists, and other health resources. Medical services are provided through Community-based Health Centers and private doctors.	X	X		
2. MCH Programs provice SCHIP and Medicaid eligibility determination and referrel.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Delaware Health Care Commission oversees the Uninsured Action Plan. This plan explores strategies to preserve and expand health insurance coverage through the State Planning Program and linking uninsured citizens with reliable health homes and affordable care through the Community Healthcare Access Program (CHAP).

c. Plan for the Coming Year
See attached resource guides in English and Spanish. We will continue to direct uninsured families and children to appropriate resources in the community for access to Federal Qualified Health Centers located throughout the state.

In 2010, Delaware Health and Social Services' Cabinet Secretary Rita Landgraf formed a Health Reform Workgroup, which is staffed by DPH, to provide strategic oversight on implementation and policy development. Many partners are included in this workgroup to address many opportunities such as health workforce development, public health evidenced-based home visiting programs, Medicaid, and insurance coverage to Delawareans as a result of the Health Reform law.

An attachment is included in this section.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		33	33	20	20
Annual Indicator	34.0	27.8	28.4	20.2	16.0
Numerator	2141	2712	2814	2075	2075
Denominator	6296	9763	9920	10264	12962
Data Source				Delaware WIC Program	Delaware WIC Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15	15	14	14	14

a. Last Year's Accomplishments

The MCH Program, the ECCS Program and Health Promotion and Disease Prevention combined efforts to provide funding and support for the development of educational modules for early education providers designed to prevent obesity among young children. This contract with the University of Delaware's Cooperative extension
developed a professional development training to licensed child care providers. The training focuses on implementing new child care regulations related to obesity prevention (reduce screen time, increase healthy eating, and increase physical activity).

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Division of Public Health MCH programs partner with Nemours X 69 Health and Prevention Services on child health issues including obesity prevention.				X
2. The DPH Health Promotion and Prevention Section has obesity prevention as a strategic objective.				X
3. Nutritionists are part of the MCH programs' staff. These programs include Smart Start, Kids KARE and Healthy Women, Healthy Babies.	X	X		
4.				
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
The MCH Program partially funded the Planned Approach to Community Health (PATCH) Project in Sussex County. PATCH is a health promotion effort that provide community food drops, community grants, and community education and awareness about health issues, including diet, nutrition, exercise and obesity prevention in early childhood.

c. Plan for the Coming Year
Once the obesity module for early child case professional development has been created, the Early Childhood Comprehensive Systems project will utilize Nurse consultants to provide the training to early childhood care providers.

Childhood obesity has been identified as a new State performance measure and priority during FY 2009 and the MCH program is currently considering additional initiatives around this issue, including the additional promotion of breastfeeding.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		11	10.9	6.5	6.6
Annual Indicator	11.2	6.8	6.8	9.7	9.7
Numerator	1272	814	814	1177	1177
Denominator	11337	11898	11898	12097	12097
Data Source				Delaware Vital Statistics	Delaware Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	9.4	9.2	9	8.8	8.6

Notes - 2009
2009 data are not available. It is anticipated that 2009 data will become available in early 2012.

Notes - 2008
2006 and 2007 data, as reported on the form are not correct. See Form-level note for accurate data. 2008 data are not available. It is anticipated that 2008 data will become available in early 2011.

Notes - 2007
2007 data are not available at this time.

a. Last Year's Accomplishments
Smoking has decreased among pregnant women in Delaware to 9.76% overall, and 12.83% among white women and 8.5% among black women. Although the prevalence of smoking during pregnancy has slightly decreased over time, white women consistently smoke more than average in Delaware.

Smoking cessation among pregnant women continues to be a focus of Smart Start, nurse home visiting program for high risk pregnant women, and the Infant Mortality Initiative Program that provides enhanced prenatal care. Women are referred to the well-established and widely recognized DPH Tobacco Prevention and Control services of Quitline and Quitnet. Through the Quitline women can access 24-hour counseling and advice from local experts. Free nicotine replacement therapy is available for those who qualify. Quitnet provides cessation information and assistance via the web.

Smoking cessation is also promoted through WIC, which serves more than half of all pregnant women in the state.

The 2008 Delaware PRAMS data indicated that 60.03% of respondents (946 of 1,576) stated that a health care worker informed them during a least one prenatal visit of how smoking during pregnancy would affect their baby.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Smoking cessation continues to be a main risk factor reduction priority in each of the Maternal and Child Health program. Women are provided counseling and educational materials to assist in smoking cessation.	X	X		
2. The MCH programs refer women to the Delaware Quitline, a statewide resource that offers support, counseling and vouchers for pharaceutical products.	X	X		
3. Smoking during pregnancy contines to be monitored through the Registry for Improved Birth Outcomes.				X
4. The Delaware Healthy Mothers and Infants Consortium partners with community agencies to address the reduction of tobacco use among pregnant women and women of childbearing age.		X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The comprehensive smoking cessation programs and services are having an impact on Delaware women. Delaware funds multiple interventions to reduce maternal smoking during pregnancy including:
• Healthy Women/Healthy Babies program aimed at recruiting women when they find out they are pregnant and providing services through the postpartum period;
• Preconception Care program aimed at recruiting non-pregnant women of childbearing age for

care;
• Delaware Quitnet/Quitline focused on smoking cessation;
• DelaWELL program initiated to offer referrals to Delawareans who want to engage in healthier lifestyles;
• Delaware Tobacco Program created a specific social marketing campaign for OB/GYNs and primary care physicians who treat pregnant women. In addition to posters and educational materials, women are given a "quit kit" that includes stress relieving items and information about tobacco cessation support services.

c. Plan for the Coming Year
The DPH Tobacco Prevention and Control Program has extensive and successful programs, health education, social marketing and resources for tobacco cessation for pregnant women. These include tobacco prevention programs such as "quit pack" which are given to OB and family practice providers statewide. In addition, Healthy Women Healthy Babies continues to offer mental health counseling for free for all women enrolled in the program. Counseling to these clients include addiction services, information and referral resources.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.5	5.5	5.4	5.4	13
Annual Indicator	5.8	13.5	8.3	8.3	8.3
Numerator	10	8	5	5	5
Denominator	170943	59228	59899	59899	59899
Data Source				Delaware Vital Statistics	Delaware Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8	8	7	7	7

Notes - 2009
2009 data are not available at this time.

Notes - 2008
2008 data not available at this time.

Notes - 2007
2007 Vital Statistics data.

a. Last Year's Accomplishments

A statewide summit was held in November 2008 to convene stakeholders vested in improving the health of adolescents, including their mental health. During the summit, it was clear that mental health and nutrition (to address obesity epidemic) are the two most important services offered by SBHC. Due to this commitment and ever-shrinking state support for SBHC, the adolescent health program within DPH created a working group to research various school-based health center models being utilized across the country.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. DPH clinic based services provide referral for depression and other mental health conditions.		X		
2. School-Based Health Centers provide mental health counseling and referral to students.	X	X		
3.				
4.				
5.				
6.				
7.				
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b. Current Activities

In December of 2009, the Division of Public Health was notified that School-Based Wellness Centers (SBWC) were not in compliance with current Medicaid reimbursement regulations. During the course of discussions on Medicaid billing with the various SBWC stakeholders the issue of providing reproductive health services at SBWC was discussed. As a result DPH will re-look at the delivery of reproductive health services within SBWC. Although STD testing is provided in 75% of all centers, none provide contraception for routine pregnancy prevention. Although this issue is controversial, it merits a discussion with each school district to share the community specific epidemiologic data that supports delivery of full reproductive health services at each SBWC.

c. Plan for the Coming Year

DPH Adolescent Health services will utilize information gained from its working group to develop a new model of service with an emphasize on the need to look outside of conventional reimbursement mechanisms to explore the feasibility of receiving reimbursement from private 3rd party payors.

Carry-out school district specific meetings with advisory boards and Parent Teacher Organizations to share community-level data about teen pregnancy, STDs and infant mortality. DPH will also include evidence that supports reproductive health services in SBWC as a means to reduce adolescent risk taking behavior by delaying initiation of sexual intercourse, reducing the frequency of partners, increasing condom use and other forms of contraception. DPH will begin the development of new consent forms including consents for reproductive health services for introduction into SBWC in FY 12

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	80	80
Annual Indicator	79.7	79.3	90.5	90.5	90.5
Numerator	145	188	182	182	182
Denominator	182	237	201	201	201
Data Source				2007 Delaware Vital Statistics	2007 Delaware Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	92	92	92	92	92

Notes - 2009
2009 data are not available at this time.

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 Vital Statistics.

a. Last Year's Accomplishments
The Delaware Healthy Mothers and Infant Consortium's Standards of Care Committee reviewed standards of care, including the American College of Obstetricians and Gynecologists state and national recommendations for preconception and prenatal care. The committee continues to monitor neonatal transport to assure proper transport to the appropriate level of care hospital.

The Standards of Care committee also facilitated care level self assessment surveys of all Delaware hospitals providing deliveries and OB care. Self assessments were reviewed with representatives of all hospitals on the committee.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Delaware Healthy Mothers and Infants Consortium, Standards of Care Committee monitors neonatal transport issues regarding transportation to the Level III facility.				X
2.				
3.				
4.				

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b. Current Activities
The Standards of Care committee is currently working with Delaware hospitals to establish a perinatal collaborative. The Delaware Healthcare Association (the hospital association) supports hospital and birthing center participation in this initiative. The collaborative is intended to advance practice standards including:

• Fetal 'Kicks Count' standards and campaign

• Appropriate administration of steroids to enhance fetal pulmonary maturity (including advancement of a common "Order Set for Preterm Admission")

• Progesterone administration for select women with a history of premature birth

• Control/oversight of infertility management

• Appropriate use of cerclage

• Avoidance of elective iatrogenic prematurity -- elective pre-39 week deliveries

c. Plan for the Coming Year
The Standards of Care Committee will continue to advance the perinatal collaborative (including the initiatives bulleted above), as well as, monitor neonatal transport issues in the state.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	75	75
Annual Indicator	83.2	73.9	66.9	66.9	66.9
Numerator	9450	8796	8092	8092	8092
Denominator	11358	11898	12097	12097	12097
Data Source				Delaware Vital Statistics	Delaware Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	68	70	72	74	76

Notes - 2009
2009 data are not available at this time.

Notes - 2008
2008 data not available at this time.

Notes - 2007
2007 Vital Statistics data.

a. Last Year's Accomplishments
The two main Infant Mortality Elimination Initiative's that provide direct patient care (preconception and prenatal care) were combined into one comprehensive program -- Healthy Women/Healthy Babies (HWHB). The HWHB program reimburses for enhanced prenatal care services for women at risk for poor birth outcomes, including those who are uninsured. Since inability to pay is a barrier to early prenatal care, HWHB will eliminate this barrier by reducing the economic burden on pregnant women and their families.

In FY 2009, 2,264 women were served by the Family Practice Team Model (the precursor to Healthy Women, Healthy Babies. Of these, 750 were pregnant African-American Women. Since its inception, based on available date, 91% of all births to women participating in this program fall within a "normal" birht weight range (2,500 grams or greater).

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Smart Start and Healthy Women, Healthy Babies engage women in early pregnancy, and provide case management and follow-up services to ensure prenatal care is available and accessible.		X		
2. Prenatal programs provide translation services to non-English speaking women to reduce barriers to care.		X		
3.				
4.				
5.				
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b. Current Activities
The Heathy Women, Healthy Babies program model has been implemented statewide. A new module has been added to an existing data system (the Newborn Screening Data System) to collect individual level data elements related to program utilization and health outcomes. Previously data were reported in aggregate at the program level. With this new capability, the program is being monitored and activities will be evaluated.

c. Plan for the Coming Year

Fully implement HWHB and assess rates of early entry into prenatal care by geographic region. Work with the Sussex County site, La Red, to increase outreach to women and education about the necessity for early prenatal care.

MCH recently established a relationship with the Sussex County Child Health Coalition to promote early prenatal care among Hispanic women.

High risk pregnant or post-partum women will be referred to Smart Start if a comparable program is not available at the health facility through Healthy Women Healthy Babies. At risk or medically fragile infants are also served by Smart Start. Use targeted home visiting as a venue to optimize individual responsibility, provide services and increase information.

D. State Performance Measures

State Performance Measure 11: *The rate of infant deaths between birth and 1 year of life.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					8
Annual Indicator		8.3	7.4	7.4	7.4
Numerator		99	90	90	90
Denominator		11898	12097	12097	12097
Data Source				Delaware Vital Statisitics	Delaware Vital Statisitics
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8	7.8	7.8	7.8	

Notes - 2009
2009 data are not available at this time.

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 Delaware Vital Statistics

a. Last Year's Accomplishments
Delaware's Infant Mortality Rate has dropped by 8 percent -- from a rate of 9.2 per 1,000 births in 2001-2005 to 8.5 in 2003-2007. Although still higher than the U.S. rate (6.8), this decrease is greater than observed nationally.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Preconception care and a lifespan approach to reproductive health are promoted through the Delaware Healthy Mother and Infant Consortium.	X	X	X	
2. Healthy Women, Healthy Babies provides wrap around services for at-risk reproductive age women.	X	X		
3. Cribs for Kids provide safe sleeping promotion and free cribs to families who cannot afford to purchase one.	X	X		
4. Family Planning, STD Prevention	X	X	X	
5. Newborn Screening			X	
6. Growing Together			X	
7. PRAMS				X
8. Child Death, Near Death and Still Birth Commission				X
9. Fetal and Infant Mortality Review				X
10. Birth Defects Registry				X

b. Current Activities
The preconception and enhanced prenatal care program known as Family Practice Team Model, is being combined into one program. This program will be called Healthy Women/Health Babies (HWHB). HWHB will use the life course model and incorporate a stronger focus on interconception care.

The CDC MCH epidemiology assignee returned to CDC in May 2009. Since June 2009, DPH has continued to contract with APS Health care to provide epidemiology, research and evaluation services for the family health programs within DPH. A large emphasis continues to be placed on research, analysis and evaluation of infant mortality elimination initiatives and those that target overall improvements in women's health before pregnancy -- preconception.

c. Plan for the Coming Year
DPH will implement a comprehensive Family Practice Team Model that streamlines services to target the highest-risk women so that pregnant women can learn from other mothers, outreach workers, nurses, social workers and nutritionists how to best care for themselves and their infants up to two years postpartum. Conduct a program evaluation of one of your Family Practice Team Model (Prenatal Care) Program's sites. Collect information on women's health history, previous pregnancy history and the services they received from the program. Additional analyses of maternal care for black women throughout the state and infant care in Kent and Sussex Counties will be performed.

DPH will implement the findings from the Fetal Infant Mortality Review (FIMR) and the Child Death, Near Death and Stillbirth Commission (CDNDSC).

DHMIC will continue to develop an initiative around raising awareness of the importance of monitoring fetal kick counts throughout the state.

Continue the study of risk facts for poor birth outcomes.

State Performance Measure 12: *The rate of live births at 32 to 36 weeks of gestation(preterm birth).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009

Annual Performance Objective					110
Annual Indicator		112.4	116.9	116.9	116.9
Numerator		1337	1414	1414	1414
Denominator		11898	12097	12097	12097
Data Source				Delaware Vital Statistics	elaware Vital Statistics
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	108	106	104	102	

Notes - 2009
2009 data are not available at this time.

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 Delaware Vital Statistics Data.

a. Last Year's Accomplishments
One of the Delaware Healthy Mother and Infant Consortium (DHMIC) initiatives includes an intervention with women most at risk for prematurity. The Prematurity Prevention Program provides progesterone therapy to women at risk for premature delivery. In FY09, 30 mothers who delivered at Christiana Care avoided premature labor and delivery. Since prematurity and low birth weight are the leading causes of infant mortality, this translates into potential lives saved.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Preconception Care	X	X	X	
2. Healthy Women, Healthy Babies	X	X		
3. Family Planning	X	X	X	
4. PRAMS				X
5. Center for Family Health Research and Epidemiology				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Delaware has implemented a social marketing campaign to develop a prematurity awareness among African American women of reproductive age. In order to reduce the number of infant deaths in Delaware, the number of premature births must be reduced. The awareness campaign targets the following misconceptions:
- Prematurity isn't that bad.
- Small babies do just fine in the NICU.
- Having a baby born before 40 weeks is easier on the mom.
- It is chic or cute to have a really small baby.

Reproductive life plans have been developed as part of a statewide social marketing campaign.

c. Plan for the Coming Year
MCHB recently applied for a First Time Motherhood Activities federal grant, and funding will support the development of a comprehensive statewide social marketing campaign. Delaware will build on existing programs such as Healthy Women/Healthy Babies (HWHB) operated by DPH with support of the Delaware Healthy Mother and Infant Consortium (DHMIC). Through this program that provides preconception, prenatal and interconception care, we touch over 11,000 people per year and almost 20 percent of all births in Delaware. The HWHB program will be enhanced through targeted social marketing to:

- Increase provider awareness of the life course perspective and their role in preconception care.
- Increase the use of reproductive life plans.
- Increase resources available for first time parents/new parent education.
- Increase resources for women who have had a previous poor birth outcome.

Several other DPH programs will be involved with project including The WIC Program, Northern and Southern Health Services, Center for Family Health Research and Epidemiology, and the Office of Health Risk and Communications.

Continue to improve outreach to monolingual Spanish speaking women to ensure those with a history of premature delivery are able to take advantage of the Prematurity Prevention Program.

State Performance Measure 13: *The rate of low birth weight and very low birth weight deliveries.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					92
Annual Indicator		94.0	92.4	92.4	92.4
Numerator		1119	1118	1118	1118
Denominator		11898	12097	12097	12097
Data Source				Delaware Vital Statistics, 2007	Delaware Vital Statistics, 2007
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	88	86	84	

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 data are not available at this time.

a. Last Year's Accomplishments
Initiatives to reduce LBW/VLBW targeted smoking and substance abuse during pregnancy. Smoking contributes for 20-30% of all low birth weight deliveries nationwide. Maternal smoking is addressed by the enhanced prenatal care program, Family Practice Team Model. Women are referred to the state's tobacco Quitline or internet-based, Quitnet. Motivational interviewing and

Stages of Change counseling is also used to encourage smoking and substance abuse cessation. Over the course of the year, the Family Practice Team Model program served 2,264 pregnant women, and 94% did not experience pregnancy complications.

In FY09, Delaware provided bilingual services to more than 500 Spanish-speaking clients. We also provided access to key prevention services such as immunizations, folic acid and genetic counseling for those at risk of having a baby with a birth defect. This program disproportionally serves African American and Hispanic women, given they are at increased risk of poor birth outcomes, including LBW/VLBW deliveries.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Preconception Care	X	X	X	
2. Healthy Women, Healthy Babies	X	X		
3. Family Planning	X	X	X	
4. PRAMS				X
5. Center for Family Health Research and Epidemiology				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continue Statewide Education Campaign, which develops and distributes resources for educating teens and adult women on subjects relating to infant mortality. Continue to distribute the Reproductive Life Plan toolkits to help teen and adult women set and follow personal goals that will help them achieve healthy pregnancies, when and if desired.

Support of the efforts of the Tobacco Prevention and Control Program to ensure all pregnant women have access to tobacco cessation counseling and services.

c. Plan for the Coming Year

In the upcoming year, we will implement a new science-based preconception/interconceptionand prenatal program to address the health of the mother from the day of her birth to the birth of her child. This multi-level approach involves the woman herself, her family, her health care provider and the community. Continue to expand the Family Practice Team Model within the new Healthy Women/Healthy Babies program.

State Performance Measure 14: *The percent of children and adolescents who are overweight or obese.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					16
Annual Indicator			17	17	13.7
Numerator					

Denominator					
Data Source				Delaware YRBS	Delaware YRBS
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	16	15	15	14	

Notes - 2009
2009 Delaware YRBS - This is a survey-based indicator and reported as a percent.

Notes - 2008
2007 YRBS

Notes - 2007
2007 YRBS

a. Last Year's Accomplishments
The Physical Activity, Nutrition and Obesity (PANO) program within the DPH Health Promotion and Disease Prevention Section has moved forward with limited state funding to develop and implement a statewide plan.

PANO formed the Delaware Coalition for Healthy Eating and Active Living (DE HEAL) to assess and implement programs in DE. The DE HEAL (Delaware Coalition to promote Healthy Eating and Active Living) continued efforts to achieve their goals and objectives. The goals are to:

• Increase physical activity
• Increase the consumption of fruits and vegetables
• Decrease the consumption of sugar-sweetened beverages
• Increase breastfeeding initiation and duration
• Reduce the consumption of high-energy-dense foods
• Decrease television viewing

The statewide coalition has established seven committees/workgroups. These include:
• Community-based programs
• School/Youth
• Environment
• Industry/Employee Health
• Policy and Legislation
• Health Care Delivery
• Research and Evaluation

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WIC	X	X	X	
2. School-Based Wellness Centers	X	X	X	
3. ECCS				X
4. Breastfeeding Promotion			X	
5. Smart Start (formerly KIDS KARE)	X	X		
6.				
7.				
8.				
9.				

10.				

b. Current Activities
The PANO program was awarded ARRA (American Reinvestment and Recovery Act) Communities Putting Prevention to Work (CPPW)funds to do the following:

• To develop and implement procedures for healthy food choices for Delaware State Parks that provides healthy eating choices and limits the availability of unhealthy foods for all parks and park facilities through procurement practices and competitive prices in the vending machines, campground shops, and concession stands. The kickoff was held at Killens Pond State Park on June 11th.
• To work with the Delaware Department of Transportation to improve signage for bicycle routes and bicycle facilities.

PANO established a very successful Farmers' Market to promote locally grown fruits and vegetables and began it's second year on June 16th.

c. Plan for the Coming Year
Continue the successful weekly farmer's market in the green space near the state legislative building.

State Performance Measure 15: *The percent of women of childbearing age (15-44) who are obese (BMI 30 or higher).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					26
Annual Indicator			27	29	29
Numerator					
Denominator					
Data Source				Delaware BRFSS	Delaware BRFSS (2008)
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	26	25	25	24	

Notes - 2009
2008 Delaware BRFSS, Women 25-44 who are obese - This is a survey-based indicator and reported as a percent.

Notes - 2008
2008 Delaware BRFSS, Women 25-44 who are obese - This is a survey-based indicator and reported as a percent.

Notes - 2007
Percent of obese women 25-34, 2007 YRBS - This is a survey-based indicator and reported as a percent.

a. Last Year's Accomplishments

The work of the PANO program in DPH and the establishment of a statewide PANO coalition (mentioned in SPM#4) positively impacts SPM#5. Achieving the goals of the coalition will positively impact the health of all Delawareans, including women of reproductive age.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Smart Start	X	X		
2. Preconception Care	X	X	X	
3. Family Planning	X	X	X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Infant Mortality Elimination program and DHMIC are developed a preconception social marketing campaign. A significant message of the campaign is the need to achieve a healthy weight before pregnancy. Novel messaging and distribution via new media (e.g. text messaging, blogs) promotes widespread dissemination of this message to women of childbearing age.

In addition, the Healthy Women, Healthy Babies program providew nutritional counseling to all overweight and obese women. The women are eligible to meet with a Registered Dietician within their current care setting to develop individual healthy eating and healthy weight goals. Impact evaluation on an individual-level will take place during the upcoming year.

c. Plan for the Coming Year

Healthy Women/Healthy Babies Program: Aimed at recruiting women when they find out they are pregnant and providing services through the postpartum period. The program teaches women how to cope with their chronic disease while pregnant and how to manage medication and eat correctly. The preconception program helps prepare women's bodies for pregnancy and gives women the tools to learn to maintain a healthy weight, eat a nutritious diet, including adequate amounts of folic acid daily, managing chronic disease, as well as being tobacco and substance free. Women in the program have access to free nutrition services through a licensed registered dietician.

Smart Start: Provides nutritional counseling for women who need additional services beyond what the nurse is able to provide.

Women, Infant, and Children (WIC) Program: Promotes healthier eating habits. WIC is a federally funded program that safeguards the health of low-income pregnant, breastfeeding and postpartum women, and infants and children five years of age. The program provides nutritious foods, information on healthy eating, breastfeeding support, and referrals to other healthcare, welfare and social services.

PANO/DE HEAL:

• Will implement tracking locations of places where Delawareans get their food (Farmers markets, super markets, convenience stores).

• Work on a project with Delaware Department of Transportation (DelDOT) to provide bicycle

facilities.
• Have a Memorandum of Agreement with DE Parks and Recreation to provide better food choices in all DE Parks. This includes menu items at concession stands as well as vending machines.
• Work with DelDOT on providing signage for bicycle routes.
• Support locally grown fruits and vegetables all throughout summer through a Farmers' Market at theLegislative Mall in the state capital.
• Promote healthy guidelines: Increase physical activity; Increase the consumption of fruits and vegetables; Decrease the consumption of sugar-sweetened beverages; Increase breastfeeding initiation and duration; Reduce the consumption of energy dense foods; and Decrease television viewing.

State Performance Measure 16: *The mortality rate among children and youth (0-21 years) due to unintentional injuries.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					10.5
Annual Indicator			15.5	15.5	15.5
Numerator			39	39	39
Denominator			251428	251428	251428
Data Source				Delaware Vital Statistics	Delaware Vital Statistics
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10.5	10	10.5	10.5	

Notes - 2009
2009 data are not available at this time.

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 Delaware Vital Statistics

a. Last Year's Accomplishments
The Bureau collaborated with the Safe Kids Coalition, Delaware Injury Prevention Coalition and Office of Emergency Medical Services to assess data and develop goals.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Injury Prevention Coalition, a group consisting of many state and community-based agencies, continues to promote injury prevention awareness throughout the state.			X	X

2.				
3.				
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10.				

b. Current Activities

As was related in Federal Performance Measure # 10, the contractor hired to assist the Bureau in absence of a CYSHCN Director interfaced with the OHS, Office of Emergency Services (OES) and the Delaware Injury Prevention Coalition (DIPC) to review and analyze data and best practices relating to this indicator. The Bureau also worked with Children's Safety Network for technical assistance. See also State Performance Measure # 20 which relates to reduction of injuries for youth aged 15-18. There is no immediate expectation that new sources of either federal or state funds will become available either in the current year or next year. Therefore, no distinct injury or violence prevention program is available through the Bureau. However, in addition to participation in DIPC, the Bureau is an active collaborator of the Safe Kids Coalition. Safe Kids Delaware is a non-profit organization established in 1989 comprised of volunteers dedicated to reducing unintentional childhood injury in children from birth to age 14. Throughout the year SK held multiple safety awareness events, educational activities and injury prevention health fairs and conferences.

c. Plan for the Coming Year

The Bureau is most likely to focus on passenger safety within the realm of unintentional injury/mortality prevention in the coming year. The new Deputy Director is likely to desire to shape the specific emphases and interventions within these performance measures overall. The Bureau will continue to actively participate in the DIPC and collaborate in all possible ways, for example, build in passenger safety messages and promote resources for child restraints to mothers, especially new mothers in addition to work targeted youth aged 15-18 and use of passenger restraints. Additionally, the Bureau is a long term collaborator with Safe Kids. Activities for the coming year include: annual Safe Kids Days in each county, an injury prevention conference, and a series of bike rodeos, walk this way events and car seat events scheduled. There should be increased opportunities to partner are likely to be identified as the new Deputy Director is selected and been oriented to Delaware systems and partners.

A Strategic Plan for Injury Prevention (2005-2010) has been developed by expert work teams from the Delaware Coalition for Injury Prevention with guidance from the Division of Public Health's Office of Emergency Medical Services. The plan provides a framework to address nine core injuries: falls, motor vehicle injuries, traumatic brain and spinal cord injuries, suicide and suicide attempts, poisoning, fire injuries, dog bites, firearm injuries, and drowning and submersion injuries. The work teams used the public health approach to define each problem, identify risks and causes, and develop interventions to increase the public's awareness about the preventability of these injuries. The plan also seeks to reduce environmental risks, impact public policy and decision-making, and redirect the economic and social losses caused by injury. Over the next year, MCH will work with the Delaware Coalition for Injury Prevention on implementing strategies identified in the state plan.

Home Visiting Services: Home visiting by nurses to families at high risk of injury is used in Delaware for a wide range of purposes, including improving the home environment, family development and addressing child behavior. Improvement in the quality of the home environment is associated with a reduced risk of some types of injury, for example falls in very young children,

with the greatest impacts found in programs using professional visitors with longer visitation schedules and those supplying and explaining safety devices. This will be key element of DPH's evidenced-based home visiting program.

State Performance Measure 17: *The percent of Delaware public high school students who currently smoke.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					10
Annual Indicator		18.2	19.1	19.1	19
Numerator					
Denominator					
Data Source				Delaware YRBS	Delaware YRBS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10	10	10	10	

Notes - 2009
2009 YRBS

Notes - 2008
2007 YRBS

Notes - 2007
2007 YRBS

a. Last Year's Accomplishments
Teens Against Tobacco Use (TATU) is a curriculum that trains adult facilitators and high school aged teens on tobacco prevention. The trained teens then take the program to middle schools and other community settings to work with younger children; Delaware Kick Butts Generation (KBG) is a program that empowers youth to develop and maintain groups in schools and communities to work on tobacco issues that are relevant to their environment. Not-On-Tobacco (N-O-T) is a smoking cessation program designed for youth that is gender specific to help them quit smoking.

Schools reached 14,500 youth in the TATU program, 51 in NOT and 27,500 in the KBG program. Another 27,700 adults and youth saw billboards or read a newsletter produced through the youth prevention program.

In June 2009, a new bill (HB211) was introduced to increase the tobacco excise tax by 45 cents. Increases in excise tax have been shown to reduce youth smoking.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Teens Against Tobacco Use training and public education.			X	
2. Delaware Kick Butts Generation youth empowerment programs.		X		

3. Youth tobacco cessation program.		X		
4. Quitline and Quitnet tobacco cessation programs.		X		
5. Reproductive Life Plans (Social Marketing)			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The adult smoking rate reached an all-time low of 17.8% and the high school smoking rate plunged to its lowest rate of 17.3%. More than 3,500 adult Delawareans enrolled in cessation counseling services: 2,346 chose Quitline (telephone); 1,773 chose face-to-face counseling; and 1,211 enrolled in Delaware Quitnet (web-based). The Tobacco Prevention Program awarded 31 community grants that will engage more than 11,500 youth and 6,200 adults in tobacco prevention activities.

c. Plan for the Coming Year

Develop prevention activities based on submissions to my7minutes.com, an interactive youth tobacco prevention website that was launched in January 2010.

Educational Campaigns: The DPH funds and conducts media campaigns such as anti-smoking TV commercial contests for Kent, Sussex, and New Castle county high schools, anti-smoking T-shirt design competitions in middle schools and high schools, and anti-smoking billboard design contest for youth. Develop a new campaign addressing other tobacco products such as cigars and smokeless tobacco.

Counseling: DPH will continue to offer free cessation counseling through the Delaware Quitline.

DPH also has a Quitnet program that is dedicated to providing comprehensive resources and support for people trying to stop smoking. The program consists of: learning from science-based stop smoking resources, getting quitting tips and advice from expert counselors, getting quit support from the QuitNet community and creating a personal quit smoking plan.

Delaware healthcare providers encourage teenagers to abstain from smoking or to quit if they currently smoke. The question is asked on paperwork given at providers' offices. If the teen is having trouble quitting, providers can prescribe prescription medication or recommendations of over-the-counter nicotine replacement treatments.

Furthermore, School-Based Health Centers will continue as a resource for teens to receive information on quitting and counseling from trained professionals.

Anti-Ash Brigade (AAB): For kids in grades 4-6. The AAB is a Delaware youth movement for children aged 8-12, dedicated to promoting the understanding of the dangers or tobacco use. The AAB is committed to decreasing the initiation of tobacco use through educational programs kids will understand. The AAB teaches Delaware youngsters how to avoid falling into the tobacco-use trap, handle-peer pressure and truly understand the dangers of tobacco use. Through age appropriate educational, social, and advocacy efforts, AAB members will become healthy lifestyle advocates.

State Performance Measure 18: *The percent of benchmark measures completed for implementation of a formal umbrella structure for organizations serving families with children with special health care needs in Delaware.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					60
Annual Indicator				20.0	80.0
Numerator				1	4
Denominator				5	5
Data Source				State Title V Program Data	State Title V Program Data
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	80	100	100	100	

a. Last Year's Accomplishments
As was related in Federal Performance Measures 2,3 4, 5, and 6, the principal strategy for achieving systems-oriented goals is through the creation of an umbrella organization mechanism for bringing the many valuable, yet disparate, informal groups and formal organizations in order to reduce fragmentation, improve information and referral, strengthen organizational capacity, and advocate for CYSHCN.

Here is a review of last year's activities to craft and release an RFP to establish the Family Support Initiative (FSI), also known as the umbrella organization.

The CYSHCN program within MCH identified the need for enhanced coordination within organizations that serve CYSHCN families. Organizations serving CYSHCN range from large, well-funded non-profit organizations to small volunteer-led entities. Most of these entities or groups have a disease/condition specific focus yet often share similar system-oriented concerns and struggle to identify resources. Recognizing this, CYSHCN conducted an assessment process to clearly identify shared concerns and unique interests of these Delawarean groups. The process was designed to promote consensus and greater understanding between groups of barriers and opportunities for cooperation. Two group meetings were held following a series of key informant interviews of stakeholders. Based on feedback from the interviews and information gleaned from interviews of states with best-practice CYSHCN coordination, the Bureau proposed the establishment of an "umbrella" organization that will serve as a fiduciary agent and single point of entry for family information and referral.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Children with Special Health Care Needs Program has implemented a Family Support Organization.				X
2.				
3.				
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
The RFP was let in November of 2009 and the contract was executed with a March 2010 start date. The Bureau met with the contractor, University of Delaware, Center for Disabilities Studies, to firmly guide the overarching goals of the FSI.

The UDS-CDS work plan for the period March 2010 -- September 2010 includes:
- A group meeting of probable collaborators to launch effort and solicit public input into Needs Assessment
- Conduct a comprehensive environmental scan
- Facilitate a Collaborator's Summit
- Web and print (large print, Braille and audio) information resources
- Communication of emerging issues, opportunities

c. Plan for the Coming Year
The activities planned for current year will likely extend into next federal FY. The next series of deliverables will include a second environmental scan to assess organizational capacity (e.g., governance), support in promotion of the state mixed-methods CYSHCN survey, continued family input into Bureau plans, and the development of the State Transition Plan. Additionally, the contractor for FSI, UDS-CDS, will conduct an environmental scan process designed to elicit all services and access information for CYSHCN providers as a principal goal. The contractor has experience in the assessment and preparation of large-scale resource tools/databases for assistive technology.

State Performance Measure 19: *The percentage of children aged 4 months to 5 years with no or low risk for developmental, behavioral or social delays.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					76
Annual Indicator				74	74
Numerator					
Denominator					
Data Source				NSCH, 2007	NSCH, 2007
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	76	78	78	80	

Notes - 2009
2007 National Survey on Children's Health - This is a survey-based indicator and reported as a percent.

Notes - 2008
2007 National Survey on Children's Health - This is a survey-based indicator and reported as a percent.

a. Last Year's Accomplishments
Standardized developmental screening among pediatric and primary care practices resulted from a collaboration between Early Childhood Comprehensive Systems and Delaware's Chapter of the

American Academy of Pediatrics.

An education campaign supported H.B. 99. This bill was subewquently signed into law and requires reimbursement for developmental screening.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Early Childhood Comprehensive Systems initiative collaborates with partners throughout the state to strengthen X 88 available early childhood developmental screening and interventions in a number of settings.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Early Childhood Comprehensive Systems initiative is continuing to work with the Delaware Chapter of the American Academy of Pediatrics and other state partners to expand developmental comprehensive screening among both pediatric and primary care practice sites.

c. Plan for the Coming Year
The Early Childhood Comprehensive Systems (ECCS) initiative will continue to work the Delaware Chapter of the American Academy of Pediatrics and other partners toward a statewide implementation of developmental screenings using a validated screening tool.

MCH will initiative a new project to promote health awareness systems change and produce a new DPH report, Early Childhood Health and Safety: A Call to Action. The work of the proposed project is to recognize the needs of the whole child and family by including outcomes inclusive of family support and parent education, health, nutrition and safety, mental health as it relates to school readiness. The ability to reach into other areas regarding social determinant factors and their effects on overall outcomes for young children will be the targeted area of interest. To initiate this process, an internal health and safety advisory team will be created. This team will be collaborative partners in the process to ensure a comprehensive foundation inclusive of health, safety, socio-cultural variables, and vital programmatic areas. The report will be designed to identify gaps related to inadequacy of health care services, lack of health insurance coverage and access to appropriate health care services, family economic factors, and elimination of health disparities.

E. Health Status Indicators

Introduction
As a leading contributor to infant mortality, Delaware has focused its efforts on reducing the number of low birth weight and very low birth weight infants. The Infant Mortality Initiative

supports an enhanced preconception, prenatal and interconception care program for at risk women. Since 2007, the program has extended to sites throughout the state, including a larger urban OB/GYN practice that serves primarily African American women. The program focuses on providing high-quality holistic medical, social, nutrition and mental health services.

Reducing the number of low and very low birth weight infants will remain of primary focus in FY11. This includes a media campaign focused on enhancing awareness about the dangers of prematurity and expanding the number of women served statewide.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.0	9.3	9.2	9.2	9.2
Numerator	1024	1112	1118	1118	1118
Denominator	11358	11898	12097	12097	12097
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data are not available at this time.

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 Vital Statistics

Narrative:
Low birth weight deliveries affect 1 in 14 babies born in the United States each year and can cause both immediate and long-term problems (Low birthweight newborns, 2002). Nationally, the low birth weight rate has increased from 7.0 in 1990 to 8.2 percent in 2005, representing a 17.1% increase (CDC, 2007). As the low birth weight rate has increased, the disparity ratio has remained consistently high. Non-Hispanic black women are nearly twice as likely to give birth to low birth weight babies compared with non-Hispanic white women (disparity ratio = 1.9) (CDC, 2007).

Delaware has the eighth worst infant low birth weight percentage in the nation (Kids Count Data Center, 2005). The percentage of low birth weight infants born in Delaware continued to increase in the early 2000s to 9.3% in the 2006 before dropping slightly to 9.2% in 2007 (Delaware Health Statistics Center, 2006, 2007).

National objectives for low birth weight include the Healthy People 2010 objective for improving maternal, infant, and child health: 16-10 Reduce low birth weight and very low birth weight deliveries (Healthy People 2010). Like the U.S., strategies aimed at reducing low birth weight in Delaware are found as components of infant mortality prevention initiatives. Reducing the prevalence of risk factors associated with poor birth outcomes, such as low birth weight

deliveries, is a Delaware Healthy 2010 goal (Healthy Delaware 2010). The state of Delaware funds the following interventions to reduce infant low birth weight:

Healthy Women, Healthy Babies program provides preconception, prenatal care and case management services to women and pregnant women at-risk for poor birth outcomes during the preconception/interconception and prenatal periods.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.0	7.3	7.6	7.6	7.6
Numerator	1024	833	885	885	885
Denominator	11358	11452	11712	11712	11712
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data are not available at this time.

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 Vital Statistics data.

Narrative:
Premature birth and fetal growth restriction are the two main causes of low birth weight deliveries (March of Dimes, n.d.). Preterm labor results in the premature birth of a low birth weight infant. Multiple pregnancies can lead to fetal growth restriction and subsequent low birth weight deliveries. Other factors that may increase the risk of giving birth to a low birth weight infant include maternal medical risks, substance use during pregnancy, inadequate weight gain during pregnancy, placental problems, and socioeconomic factors such as low income and lack of education. Prenatal smoking and alcohol consumption can limit fetal growth and result in low birth weight deliveries (DHHS, 2004; ACOG, 2000; Berghella, 2007). Pregnant women who smoke are nearly twice as likely to deliver a low birth weight infant compared with non-smokers (March of Dimes, n.d.).

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.6	2.0	1.7	1.7	1.7
Numerator	182	237	201	201	201

Denominator	11358	11898	12097	12097	12097
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data are not available at this time.

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 Vital Statistics data.

Narrative:
In Delaware, during the 2002-2006 time period, the primary cause of infant death was prematurity and low birth weight deliveries (Infant Mortality, 2006). Infant low birth weight is a major predictor of infant mortality (Healthy Start Association, n.d.). Low birth weight babies are more likely than normal weight babies to have health problems during the newborn period. Many of these babies require specialized care in the Neonatal Intensive Care Unit (NICU) (University of Virginia Health System, n.d.; Russell et al., 2007). Low birth weight babies may also suffer from Respiratory Distress Syndrome and require additional oxygen and mechanical ventilation to breathe until their lungs mature (March of Dimes, n.d.). A major proportion of pediatric hospital stays in the United States are for conditions in the neonatal period, which are among the most expensive diagnoses for all infants. A cross-sectional study using the 2001 Nationwide Inpatient Sample from the Healthcare Cost and Utilization Project found that preterm/low birth weight admissions totaled $5.8 billion, representing 47% of the costs for all infant hospitalizations (Russell et al, 2007). Other problems common in low birth weight infants include neurological problems, weakened immune system, and difficulty regulating body temperature, eating and gaining weight. In addition, low birth weight infants are at risk for experiencing Sudden Infant Death Syndrome (March of Dimes, n.d.).

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.6	1.5	1.3	1.3	1.3
Numerator	182	175	149	149	149
Denominator	11358	11452	11712	11712	11712
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

2009 data are not available at this time.

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 Vital Statistics data.

Narrative:
Reducing the rate of low birth weight and very low birth weight infants has been identifed as a State Priority.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.0	8.0	3.6	3.6	3.6
Numerator	66	11	6	6	6
Denominator	826523	137313	168487	168487	168487
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data are not available at this time.

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 Vital Statistics data.

Narrative:
Once children reach the age of five years, unintentional injuries are the biggest threat to their survival. Unintentional injuries are also a major cause of disabilities, which can have a long-lasting impact on all facets of children's lives: relationships, learning and play (Borse, et al., 2008).

Nationally, data from 2000 -- 2006 indicates that on average, 12,175 children 0 to 19 years of age died each year in the United States from an unintentional injury. Males had higher injury death rates than females with the death rate for males almost two times the rate for females, and males had a higher injury death rate compared to females in all childhood age groups. Injuries due to transportation related incidents were the leading cause of death for children. The types of predominant injuries vary with the age of the child.

The leading causes of injury death differed by age group:
• For children less than 1 year of age, two--thirds of injury deaths were due to suffocation.
• Drowning was the leading cause of injury death for those 1 to 4 years of age.
• For children 5 to 19 years of age, the most injury deaths were due to being an occupant in a motor vehicle traffic crash (Delaware health and Social Services, 2008).

The poisoning death rate for those older than 15 years of age was at least five times the rates of the younger age groups, and the suffocation death rate for infants was over 16 times the rates for all older age groups.

Nationally, injuries due to falls were the leading cause of nonfatal injury. Each year, approximately 2.8 million children had an initial emergency department visit for injuries from a fall. For children less than 1 year of age, falls accounted for over 50% of nonfatal injuries.

Nonfatal injury rates varied by age group:
• Nonfatal suffocation rates were highest for those less than 1 year of age.
• For children 4 years and younger, rates for the categories of fires or burns, and drowning were highest.
• Children 1 to 4 years of age had the highest rates of nonfatal falls and poisoning .
• Injury rates related to motor vehicles was highest in children 15 to 19 years of age

Risk for injury death varied by race. Injury death rates were highest for American Indian and Alaska Natives and were lowest for Asian or Pacific Islanders. Overall death rates for whites and African--Americans were approximately the same (World Health Organization, 2008).

In Delaware, for the period from 1996 -- 2005, unintentional injuries comprised 47.3% of the deaths for children between the ages of 0 and 19. Assault caused 8.3% of deaths, self-inflicted injuries 6.8%, undetermined causes 1.2% and all other causes 36.4%

For the time period 2002 -2005, for ages 0 -- 19, falls were the leading cause of hospitalization, followed by motor vehicle related accidents, and poisoning (CDC, 2004).

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	3.1	3.6	1.2	1.2	1.2
Numerator	26	5	2	2	2
Denominator	826279	137313	168487	168487	168487
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data are not available at this time.

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 Vital Statistics data.

Narrative:
Young drivers (teens) and occupants (teens and children) have a very high rate of injury and death from motor vehicle accidents compared with other age groups. For younger children, injuries are due to improper seat belt use, improper safety seat placement and riding in the front of a vehicle rather than the back. For teen drivers, injuries from crashes are attributed to speeding and inattentive driving and lack of seat belt use (CDC, 2008).

For children, ages 1-4, for the 1996-2005 time period, there were 17 deaths.

For ages 1-4, for the time period 2002-2005, the hospitalizations were 42. For ages 5-9 there were 71 hospitalizations.

For the time period 1996-2005, the death rate for Whites was 11.27 (per 100,000) while that of Blacks was 6.11. For hospitalizations during the period 2002-2005, the rate for Whites was 62.0 and that of Blacks 70.1 (Delaware Health and Social Services, 2008).

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	33.5	25.7	28.3	28.3	28.3
Numerator	38	21	33	33	33
Denominator	113580	81711	116509	116509	116509
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data are not available at this time.

Notes - 2008
2008 data are not available at this time.

Notes - 2007
2007 Vital Statistics data.

Narrative:

Nationally, during 2005, 4,544 teens between the ages of 16 to 19 died of injuries caused by motor vehicle crashes. Teenagers accounted for 10 percent of the US population and 12 percent of the motor vehicle crash deaths. On a per mile driven basis teen drivers ages 16 to 19 are four times more likely than older drivers to crash (CDC, 2008).

In Delaware the motor vehicle related hospitalization rate for teens, age 15-19 years, is 81.6 per 100,000 for the 2002-2005 time period. The overall rate for the 1-9 age range is 70.1 per 100,000. For the age range 1-19 being an occupant of a vehicle accounted for 70% of the hospitalizations. The number of deaths for this time period is 85, with about half being listed as an occupant of a vehicle (Delaware Health and Social Services, 2008).

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.0	9.0	3.6	3.6	3.6
Numerator	15	15	6	6	6
Denominator	166977	166977	168487	168487	168487
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data are not available at this time. Data are based on 2007 Vital Statistics records.

Notes - 2008
2008 data are not available. Data are based on 2007 Vital Statistics records.

Notes - 2007
2007 Vital Statistics Data.

Narrative:
Children are not small adults. Their abilities and behavior differ from those of adults. Children's physical and mental abilities, degree of dependence, type of activities and risk-taking behaviors all change substantially as they grow older. But as children develop, their curiosity and need to experiment do not always match their ability to understand or to respond to danger, leaving them at risk of injury. Children's injuries are thus highly related to the type of activities they undertake, and this in turn is related to their age and stage of development.

Children living in poverty are more likely to be exposed to hazardous environments including high-volume, fast-moving traffic, lack of space and facilities for safe play, cramped living conditions, unprotected windows and open roofs, and stairs without handrails.

A number of physical characteristics make children vulnerable to injuries. Their small size increases their risk in a road environment. They are less visible than adults and if hit by a vehicle, they are more likely than an adult to sustain a head or neck injury. At the same time, small

children have difficulty seeing over vehicles, judging the speed of oncoming vehicles and judging the distance of a vehicle from the sound of its engine. Infants' skin burns deeper, quicker and at lower temperatures than the thicker skin of adults. In addition, certain physical characteristics of young children may affect injury outcomes. For example, a particular amount of a poisonous substance will more likely be toxic for a child than an adult because of the child's smaller body mass. Children's smaller size also creates a risk of entrapment of body parts, most dangerously for the head ((Borse, et al., 2008).

In addition to death from unintentional injury, millions of children require hospital care for non-fatal injuries. Many of these are left with some form of disability, often with lifelong consequences. Road traffic crashes and falls rank within the top 15 causes of disease burden worldwide for children 0--14 years of age. And for injury survivors, the need for care and rehabilitation of the injury and the potential for permanent disability can have far-reaching impacts on their future, their health, education, social inclusion and on their parents' livelihood.

For many parents, the grief of unexpectedly losing a child to an injury can take decades to heal and for many it never does. For some families the emotional pain is even greater when they realize simple measures could have prevented the incident. Even when the outcome of an injury is not fatal, the medical costs and the special care that are often needed for a severely injured or disabled child can put a huge financial demand on parents, and cause great difficulties for families or caretakers.

In Delaware, for the time period 2002 - 2005, injury related hospital admissions totaled nearly $32 million in charges. For the 1996 -- 1999 time period the charges were $19 million.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.0	9.0	1.2	1.2	1.2
Numerator	15	15	2	2	2
Denominator	166977	166977	168487	168487	168487
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data are not available. Provisional data based on 2007 Vital Statistics records.

Notes - 2008
2008 data are not available. Provisional data based on 2007 Vital Statistics records.

Notes - 2007
2007 Vital Statistics Data.

Narrative:

Risk factors for teen driver accidents include:

• Teens are more likely to speed and have shorter following distances.
• Teens have the lowest rate of seatbelt use compared with other age groups.
• Nationally, in 2005, half of teen deaths from motor vehicle crashes occurred between 3:00p.m. and midnight and 54% occurred on Friday, Saturday or Sunday.
• In a national survey from 2005, nearly 3 out of 10 teens reported that within the previous month they had riddden in a vehicle where the driver had been drinking.
• Having teen occupants increases the crash risk of unsupervised teen drivers.
• Crash risk is high the first year that teenagers are eligible to drive (CDC, 2008).

Risk factors for children include:

• Sitting in the front seat.
• Not being buckled up.
• Improper or non-use of safety seats.

Nationally, males ages 15-24 account for 30% of the total costs of motor vehicle injuries while making up only 14% of the population (CDC, 2008). In Delaware motor vehicle injuries totaled $13,085,329 in hospital charges from 2002-2005 (Delaware Health and Social Services, 2008). For serious injuries, there are long term consequences with ongoing costs for health care, rehabilitation services, loss of wages and lost education.

Research suggests that comprehensive graduated driver's license programs are associated with reductions of 38% in fatal crashes among 16 year old drivers. Graduated driver licensing programs are designed to allow teens to get their initial driving experiences under low risk conditions (CDC, 2008; Delaware Health and Social Services, 2008).

Young children should always ride in the back seat and buckled in. Infants should be in safety seats, properly buckled, and facing the rear of the vehicle. Parents and caregivers should learn proper safety seat placement and usage.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	200.7	200.7	176.0	176.0	176.0
Numerator	228	228	205	205	205
Denominator	113580	113580	116509	116509	116509
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data are not available at this time.

Notes - 2008
2008 data are not available.

Notes - 2007
2007 Hospital Discharge data.

Narrative:
Research suggests that comprehensive graduated driver's license programs are associated with reductions of 38% in fatal crashes among 16 year old drivers. Graduated driver licensing programs are designed to allow teens to get their initial driving experiences under low risk conditions (CDC, 2008; Delaware Health and Social Services, 2008).

Young children should always ride in the back seat and buckled in. Infants should be in safety seats, properly buckled, and facing the rear of the vehicle. Parents and caregivers should learn proper safety seat placement and usage.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	36.8	37.8	34.0	37.0	37.0
Numerator	1064	1099	1000	1074	1074
Denominator	28935	29054	29397	29042	29042
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data are not available at this time.

Notes - 2008
Delaware STD Program (number of cases); Delaware Population Projections (v2009) - Number of women, aged 15-19 in 2008.

Narrative:
Compared to older adults, sexually active adolescents 15-19 years of age and young adults 20-24 years of age are at a higher risk for acquiring STDs for a combination of behavioral, biological, and cultural reasons. For some STDs, for example, Chlamydia, adolescent women may have a physiologically increased susceptibility to infection due to increased cervical ectopy. Cervical ectopy is how doctors describe the condition when columnar cells from the endocervix are present on the ectocervix, and thus more susceptible to infection. In particular, columnar cells are more likely to be infected by chlamydia, gonorrhea, and certain forms of HPV. Some degree of ectopy is normal during puberty, but the amount of ectopy usually decreases over time as a natural consequence of aging. The higher prevalence of STDs among adolescents also reflects multiple barriers to accessing quality STD prevention services, including lack of insurance or other ability to pay, lack of transportation, discomfort with facilities and services designed for

adults, and concerns about confidentiality. Recent estimates suggest while representing 25% of the ever sexually active population, 15-24 year-olds acquire nearly half of all new STDs (CDC, 2007).

The Centers for Disease Control and Prevention released a study in 2008 that estimated one in four (26 percent) young women between the ages of 14 and 19 in the United States -- or 3.2 million teenage girls -- is infected with at least one of the most common sexually transmitted diseases (HPV, chlamydia, herpes simplex virus, and trichomoniasis). The study also finds that African-American teenage girls were most severely affected. Nearly half of the young African-American women (48 percent) were infected with a STD, compared to 20 percent of young white women. The two most common STDs overall were human papillomavirus, or HPV (18 percent), and chlamydia (4 percent). Data were based on an analysis of the 2003-2004 National Health and Nutrition Examination Survey.

Chlamydia rates for persons 15-19 years of age continue to increase as they have for all age groups. Between 2006 and 2007, the increase for those 15-19 years of age was 7.7%. As in previous years, in 2007, 15-19 year old women had the highest rate (3,004.7 per 100,000 population) of Chlamydia infection compared to any other age/sex group. For the third consecutive year, gonorrhea rates for persons 15-19 years of age increased. Between 2006 and 2007, the increase for 15-19 years of age was 2.1%. In 2007 15-19 year old women had the highest rate (647.9 per 100,000 population) of gonorrhea infections compared with any other age/sex group.

Programs in Delaware include:
• The Division of Public Health provides testing, counseling and treatment for gonorrhea, syphilis, Chlamydia, and other conditions that can be sexually transmitted.
• The Sexually Transmitted Disease Program provides statewide management, education and training for the prevention and treatment of STDs.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.3	10.1	10.3	11.5	11.5
Numerator	1351	1469	1499	1655	1655
Denominator	145668	145906	145178	144325	144325
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data are not available.

Notes - 2008
HIV/STD/HCV Program

Narrative:

Sexually transmitted diseases (STDs) are infections that can be transferred from one person to another through any type of sexual contact. STDs are sometimes referred to as sexually transmitted infections (STIs) since they involve the transmission of a disease-causing organism from one person to another during sexual activity. It is important to realize that sexual contact includes more than just sexual intercourse (vaginal and anal). Sexual contact includes kissing and oral-genital contact. STDs probably have been around for thousands of years, but the most dangerous of these conditions, the acquired immunodeficiency syndrome (AIDS), has only been recognized since 1984.

Many STDs are treatable, but effective cures are lacking for others, such as human immunodeficiency virus (HIV), human papillomavirus (HPV), and hepatitis B and C. Even gonorrhea, once easily cured, has become resistant to many of the older traditional antibiotics. Many STDs can be present in, and spread by, people who do not have any symptoms of the condition and have not yet been diagnosed with a STD. Therefore, public awareness and education about these infections and the methods of preventing them is important.

Programs in Delaware include:
• The Division of Public Health provides testing, counseling and treatment for gonorrhea, syphilis, Chlamydia, and other conditions that can be sexually transmitted.
• The Sexually Transmitted Disease Program provides statewide management, education and training for the prevention and treatment of sexually transmitted diseases.
• School Based Wellness Centers provide a range of health services that include STD testing and counseling and are tailored to meet that needs of teens.
• Under Title X of the Public Health Services Act, the Division of Public Health offers a wide range of reproductive health services and supplies to both teens and adults. Services include but are not limited to physical exam including pap smear and clinical breast exam, birth control supplies, STD testing and HIV education, counseling and testing.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	11592	8256	2998	0	0	0	0	338
Children 1 through 4	46365	33022	11991	0	0	0	0	1352
Children 5 through 9	56469	40111	14362	0	0	0	0	1996
Children 10 through 14	54614	37355	14637	0	0	0	0	2622
Children 15 through 19	59763	41134	16257	0	0	0	0	2372
Children 20 through 24	57642	40599	15024	0	0	0	0	2019
Children 0 through 24	286445	200477	75269	0	0	0	0	10699

Notes - 2011

Narrative:
Demographic information regarding children 0-24 for 2009 is derived from Delaware Annual Population Projections.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	10840	752	0
Children 1 through 4	43351	3014	0
Children 5 through 9	52799	3670	0
Children 10 through 14	49566	5048	0
Children 15 through 19	55878	3885	0
Children 20 through 24	53895	3747	0
Children 0 through 24	266329	20116	0

Notes - 2011

Narrative:
Demographic information regarding children 0-24 for 2009 is derived from Delaware Annual Population Projections. Hispanics, as a percent of the population, continue to increase at greater rates among the child-aged population in Delaware.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	17	6	11	0	0	0	0	0
Women 15 through 17	387	200	182	1	2	0	0	2
Women 18 through 19	847	497	338	2	5	0	0	5
Women 20 through 34	9195	6364	2363	10	430	3	0	25
Women 35 or older	1651	1197	363	2	88	0	0	1
Women of all ages	12097	8264	3257	15	525	3	0	33

Notes - 2011

Narrative:

Data are from the 2007 Delaware Vital Statistics records. Births in the state have remained consistent (at between 12,000 and 13,000 live births annually) since 2007.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	13	4	0
Women 15 through 17	296	91	0
Women 18 through 19	688	159	0
Women 20 through 34	7691	1504	0
Women 35 or older	1492	159	0
Women of all ages	10180	1917	0

Notes - 2011

Narrative:
Data are from the 2007 Delaware Vital Statistics records. It is generally thought that the Hispanic population, including the proportion of Hispanic live births, is increasing at a greater rate than the general population.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	90	52	37	0	1	0	0	0
Children 1 through 4	7	4	2	0	1	0	0	0
Children 5 through 9	2	2	0	0	0	0	0	0
Children 10 through 14	6	4	1	0	1	0	0	0
Children 15 through 19	34	23	10	0	1	0	0	0
Children 20 through 24	54	32	20	0	2	0	0	0
Children 0 through 24	193	117	70	0	6	0	0	0

Notes - 2011

Narrative:

Data are from the 2007 Delaware Vital Statistics records. In Delaware, due to small cell sizes, year to year fluctuations in death rates among specific child age groups in the State result in occasional instability for comparison purposes.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	71	19	0
Children 1 through 4	7	0	0
Children 5 through 9	2	0	0
Children 10 through 14	6	0	0
Children 15 through 19	28	6	0
Children 20 through 24	52	2	0
Children 0 through 24	166	27	0

Notes - 2011

Narrative:
Data are from the 2007 Delaware Vital Statistics records. In Delaware, due to small cell sizes, year to year fluctuations in death rates among specific child age groups in the State result in occasional instability for comparison purposes.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	224407	159878	60245	0	0	0	0	4284	2009
Percent in household headed by single parent	35.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2008
Percent in TANF (Grant) families	4.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2009
Number enrolled in Medicaid	106259	39250	45198	199	1592	0	0	20020	2009
Number enrolled in SCHIP	6090	0	0	0	0	0	0	6090	2009
Number living in	1372	0	0	0	0	0	0	1372	2009

foster home care									
Number enrolled in food stamp program	50998	0	0	0	0	0	0	50998	2009
Number enrolled in WIC	12962	0	0	0	0	0	0	12962	2009
Rate (per 100,000) of juvenile crime arrests	2620.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	5.1	4.1	6.9	0.0	0.0	0.0	0.0	0.0	2009

Notes - 2011
Data are from 2009 Delaware Population Projections. Projections only provide estimates for White, Black and Other.

2006-2008 Average. Children in One-Parent Families, Center for Applied Demography and Survey Research, University of Delaware (as reported in 2010 KIDS COUNT Fact Book). According to the U.S. Census (2000):

19.9% of White Children live in single parent households;
57.5% of Black Children live in single parent households;
8.8% of Asian Children live in single parent households; and
34.5% of Hispanic Children live in single parent households.

In August 2009, there were 8,930 children in the TANF Program (Delaware Health and Social Services).

Monthly CHIP Enrollment, June 2009

2010 KIDS Count

2009 WIC Program Data

KIDS COUNT 2010 (Delaware Statistical Analysis Center)

2008/2009 School Year - Delaware Department of Education

2010 KIDS COUNT (Department of Services for Children, Youth and Their Families).

Narrative:
Table 9A presents miscellaneous demographic data. Race-specific estimates for a number of the items are not available or not captured.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	199387	25021	0	2009
Percent in household headed by single parent	0.0	0.0	35.4	2008
Percent in TANF (Grant) families	0.0	0.0	4.0	2009
Number enrolled in Medicaid	86239	20020	0	2006
Number enrolled in SCHIP	0	0	6090	2009
Number living in foster home care	0	0	1370	2009
Number enrolled in food stamp program	0	0	50998	2009
Number enrolled in WIC	0	0	12962	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	2620.0	2009
Percentage of high school drop-outs (grade 9 through 12)	0.0	6.6	0.0	2009

Notes - 2011
2006-2008 Average. Children in One-Parent Families, Center for Applied Demography and Survey Research, University of Delaware (as reported in 2010 KIDS COUNT Fact Book). According to the U.S. Census (2000):

19.9% of White Children live in single parent households;
57.5% of Black Children live in single parent households;
8.8% of Asian Children live in single parent households; and
34.5% of Hispanic Children live in single parent households.

In August 2009, there were 8,930 children in the TANF Program (Delaware Health and Social Services).

Monthly CHIP Enrollment, June 2009

2010 KIDS COUNT

2009 WIC Program Data

KIDS COUNT 2010 (Delaware Statistical Analysis Center)

2008/2009 School Year - Delaware Department of Education

2010 KIDS COUNT (Department of Services for Children, Youth and Their Families).

Narrative:
Table 9B presents miscellaneous demographic data. Ethnicity-specific estimates for a number of the items are not available or not captured.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	**Total**

Living in metropolitan areas	0
Living in urban areas	185979
Living in rural areas	42824
Living in frontier areas	0
Total - all children 0 through 19	228803

Notes - 2011

Narrative:
Although large portions of Kent and Sussex County are rural areas, most of the state's children reside in urban areas along the Washington-Boston corridor.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	896880.0
Percent Below: 50% of poverty	7.0
100% of poverty	14.0
200% of poverty	30.0

Notes - 2011
2010 Population Projection, All Ages (Delaware Population Projections, 2008).

Based on 2007-2008 Data reported from Kaiser Family Foundation retrieved on 6/14/2010 from www.statehealthfacts.org

Based on 2007-2008 Data reported from Kaiser Family Foundation retrieved on 6/14/2010 from www.statehealthfacts.org

Based on 2007-2008 Data reported from Kaiser Family Foundation retrieved on 6/14/2010 from www.statehealthfacts.org

Narrative:
Health Status Indictor 11 presents the poverty-level distribution based on estimates from state population projections.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	232255.0
Percent Below: 50% of poverty	7.0
100% of poverty	20.0
200% of poverty	30.0

Notes - 2011

2010 Projected Population, Ages 0-19 (Delaware Population Consortium, 2008).

Based on 2007-2008 Data reported from Kaiser Family Foundation retrieved on 6/14/2010 from www.statehealthfacts.org

Based on 2007-2008 Data reported from Kaiser Family Foundation retrieved on 6/14/2010 from www.statehealthfacts.org

Based on 2007-2008 Data reported from Kaiser Family Foundation retrieved on 6/14/2010 from www.statehealthfacts.org

Narrative:
Health Status Indicator 12 presents the population distribution for children, 0-19 years, based on population projections.

F. Other Program Activities

The Office of Women's Health works to improve the health of all women in Delaware. Recent activities / accomplishments include:

SUSSEX HEART TRUTH CAMPAIGN -- The Delaware Office of Women's Health (OWH) successfully organized and presented the Sussex Heart Truth Campaign with its partners: La Red Health Center, the Delaware Division of Public Health's Diabetes Prevention and Control Program and DPH's Southern Health Services Section.
Between April 20 and June 8, 13 lectures highlighted by Powerpoint slides were held in Sussex County churches and community centers. Speaker presentations (in English and Spanish) covered the definition of heart disease, risk factors, methods to prevent heart disease, symptoms of stroke and myocardial infarction, and the frequent results of heart disease.

Most attendees were women aged 18-60 years. Participants represented the following ethnicities: 65% African American, 25% Hispanic, 7% Caucasian, 0.5% Asian American, and 1% 'Other' (does not sum to 100% due to rounding error). Of the 130 consenting individuals screened, 84% were overweight or obese; 64% were hypertensive or pre-hypertensive; and 57% were diabetics or pre-diabetics.
A few rare attendees with excessively high blood pressures or blood glucose levels were referred to private physicians and La Red Health Center. Although not required by the grant, public health nurses followed some participants to assist them in altering health behaviors.

DIMINUTION OF HEALTH DISPARITIES --The OWH extended its support of evidence-based programs and efforts to diminish health disparities through speaking engagements, such as at the Visions of Justice X conference in November. It also reviewed projects, such as the Kaiser Family Foundation's "Putting Women's Healthcare Disparities on the Map" for a local African American women's charitable group, Alpha Kappa Alpha.

DOMESTIC VIOLENCE PREVENTION -- The OWH became increasingly involved in preventing domestic violence:
• The Office supported the active Campaign/Walk of the Whitney's Lights Violence Against Women Group. Over 500 persons celebrated the life of Dr. Whitney Lucas and to affirm their commitment to end domestic violence.
• The OWH is a member and consultant to the Delaware Task Force on Teen Dating Violence.
• The OWH continues to participate in the Delta Project of the Delaware Coalition Against Domestic Violence, which formulated a state plan to prevent domestic violence.

The Office of Minority Health works to improve cultural competence and reduce disparities in Delaware. Recent activities / accomplishmens include:

HEALTH DISPARITIES -- OMH and the Metropolitan Wilmington Urban League produced Blueprint for Action. The report summarizes the recommendations generated from the Stronger Together II Minority Health Summit held on March 12, 2009. Another collaboration with the League created the Delaware Health Equity Consortium.

FUNDING -- OMH received the fourth of the five-year, federally funded State and Territorial Disparities Elimination Partnership Grant. Although funding was reduced, OMH was able to continue the contractual partnership with Delaware State University for the Health Professions Academy and provide resources to develop DPH's cultural competency training series. The grant also funds the interpreter training for 2009 and supports OMH's one FTE.

HEALTH PROFESSIONS ACADEMY -- Through this initiative, DPH seeks to increase students' likelihood of pursuing health careers by introducing fourth, fifth and sixth graders to health professions. Students also strengthen their math and science skills. Twenty-eight students enrolled and completed the 2009 class; 38 are enrolled in the 2009-2010 program. Partners are DPH's Rural Health Program, Delaware State University, and the Delaware Chapter of the National Medical Association.

CULTURAL COMPETENCY -- OMH partnered with the Office of Workforce Development to develop DPH: Journey to Cultural Competence," offered year-round. Thirteen DPH staff members were trained as facilitators. Secondly, OMH engaged Social Solutions, a training and consulting firm, to coordinate a series of workshops to build a culturally competent health care system in Delaware. Approximately 163 professionals attended the five trainings and gave overwhelmingly positive evaluations.

MEDICAL INTERPRETER TRAINING -- In April 2009, OMH coordinated and hosted its seventh "Bridging the Gap" Medical Interpreter Training. Of the 24 registrants, 21 (87.5%) successfully completed the training. Of the 93 certificate holders, 79 are registered members of Delaware's medical interpreter corps. OMH responded to several community requests to locate interpreters. In May 2009, interpreters staffed DPH's H1N1 Influenza Call Center. In the fall, about 20 interpreters worked at six mass vaccination clinics arranged in response to the epidemic.

OMH WEBSITE -- OMH's new website offers information on Delaware disparities, statistics, and upcoming trainings. Books, reports and links are included. Visit it at http://www.dhss.delaware.gov/dhss/dph/mh/minority.html.

The Special Needs Alert Program (SNAP) recognizes children with special medical needs child when the family calls 911. Since 2004, parents/guardians have enrolled over 181 children in SNAP statewide. Part of enrollment is completing a set of forms which includes a consent form giving permission to share medical information with local EMTs and paramedics so they can access it on the way to, or prior to an emergency call. Once paperwork is completed, the information is entered in a secure SNAP electronic data base located in the Office of EMS. The child's medical information is given to the 911 dispatch center, the county based paramedic service and the local fire company upon enrollment and is made accessible to responding units.

G. Technical Assistance

Currently, Delaware does not have a structured long-term follow up for newborns diagnosed with disorders or hearing loss. Each year, DE screens about 13,000 babies per year for metabolic disorders and for hearing loss. The DE MCHB would like to begin exploring its role in long-term follow-up for individuals with disorders identified through its state newborn testing

(metabolic/hearing) efforts, by identifying and assessing key challenges, quality assurance activities, costs and long-term follow-up of state newborn screening programs. Technical assistance would be valuable to determine the feasibility, and identify best practices (i.e. review six states who as of 2006, have actively engaged in planning LTFU Newborn Screening program activities: Louisiana, Michigan, New Jersey, Pennsylvania, Oregon and Washington) on structure and implementation of long-term follow up.

In 2010, the Early Childhood Comprehensive Systems (ECCS) Projgram will heighten statewide awareness of early childhood "health" systems change efforts. Six priority areas will facilitate increased awareness and support effective decision-making and policy change to improve health outcomes and support school readiness for young children:

- Addressing Health Disparities for young children and their families
- Physical Activity, Obesity and Nutrition prevention in early childhood
- Patient-Centered Medical Homes
- Developmental Screening
- Child Care Health Consultant
- Enhancing Statewide Home Visitation

The importance of child health to school readiness and early elementary success is widely accepted. Yet, many state and community efforts to improve school readiness focus primarily on strengthening early learning systems such as child care and preschool. Too often child health is viewed as separate and distinct from early childhood care and learning rather than as an integral part of an overall school readiness strategy.

The MCHB's Early Childhood Comprehensive Systems (ECCS) is a major systems change effort with outcomes that may not be apparent for several years. This year, MCHB will build on the following ECCS goals:
- Ensure that all of Delaware's children, including those with special health care needs, are healthy and ready to learn by school entry; and
- Ensure that DE parents and families have knowledge of and access to appropriate services for their children including medical, mental health, quality early care and education, parent education and family supports

The initial project to promote health awareness systems change effort will be to produce a MCHB report, Early Childhood Health and Safety: A Call to Action. The report will be designed to identify gaps related to inadequacy of health care services, lack of health insurance coverage and access to appropriate health care services, family economic factors, and elimination of health disparities.

MCHB is requesting Technical Assistance with this ECCS project.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	1962811	1962811	1966687		1966509	
2. Unobligated Balance *(Line2, Form 2)*	485507	485507	568010		400000	
3. State Funds *(Line3, Form 2)*	9988654	9988654	9922543		9589395	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	1200000	1200000	784800		784800	
7. Subtotal	13636972	13636972	13242040		12740704	
8. Other Federal Funds *(Line10, Form 2)*	1644687	1644687	1510076		1539610	
9. Total *(Line11, Form 2)*	15281659	15281659	14752116		14280314	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	4103603	3588691	4199811		3353814	
b. Infants < 1 year old	5303603	3582789	4984610		3348298	
c. Children 1 to 22 years old	1874207	2420240	1805491		2261837	
d. Children with	2140159	1655528	2086058		1543437	

Special Healthcare Needs						
e. Others	0	2287308	0		2137609	
f. Administration	215400	102416	166070		95709	
g. SUBTOTAL	13636972	13636972	13242040		12740704	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		94466		100000	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	0		0		0	
j. Education	0		0		0	
k. Other						
ECCS	140000		105000		132000	
PRAMS	80000		95000		85000	
TItle X	0		0		1222610	
EHDI	0		125000		0	
Title X	1090610		1090610		0	
Newborn Hearing	120833		0		0	
TBI	118600		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	3430620	4342818	3529324		4058584	
II. Enabling Services	3357733	6329719	3435200		5915444	
III. Population-Based Services	3901661	1258173	3372775		1172088	
IV. Infrastructure Building Services	2946958	1706262	2904741		1594588	
V. Federal-State Title V Block Grant Partnership Total	13636972	13636972	13242040		12740704	

A. Expenditures

Title V Maternal and Child Health Block Grant funding has historically funded staff positions within the Division of Public Health's clinic-based MCH programs, including Smart Start, Kids Kare, Child Development Watch and the Oral Health program. As a result, most of the federal allocation of each year's MCH Block Grant Award is budgeted for staff salaries, other employment costs (OEC) and indirect costs. Staffing vacancies and state hiring freezes over recent years has resulted in an on-going moving bubble of unexpended funds from current year funds. This year, for example, we anticipate $400,000 will remain as of 9/30/10 from the federal fiscal year 2010 award.

In addition to staff salaries and associated employment costs, the Title V funds supported a number of strategic initiatives over the past year:

1) Consultant (Children with Special Health Care Needs) ($49,000). During FFY 2009 and continuing through FY 2010, the Delaware MCH program retained the services of a consultant to assist with the development of several strategic initiatives related to Children with Special Health Care Need. These initiatives included development of the Family Support Initiative concept, assisting with the needs assessment regarding Children with Special Health Care Needs and development of a training for oral health providers related to Children with Special Health Care Needs.

2) Family Support Initiative - The Family Support Initiative supports organizations and agencies throughout Delaware that focus on issues related to Children with Special Health Care Needs and their families. The initial year's contract is budgeted at $150,000. As described elsewhere in this application, the contract is with the University of Delaware's Center for Disabilities Studies.

3) Dental Mobile Van - Title V MCH funds ($35,000) supported, in part, the purchase of a mobile dental van. This mobile dental office is used throughout the state for preventive dental services for children.

4) Smart Start "Best Start, Breast is Best". MCH Funds ($30,000) were utilized to expand a pilot project, "Best Start," statewide within the Smart Start program. The Best Start enhancement to Smart Start offers support for women to initiate and maintain breastfeeding through the first six months of an infant's life. Breast pumps, educational materials and other supplies are made availabe to women who breast feed their infants. These services are for women who are not WIC eligible or as an enhancement for services/supplies that WIC does not cover. A second part of this project is an annual conference "Breast is Best." 2010 marked the second year for this statewide conference that attracted over 130 professionals from throughout the state.

5) Consultant (Home Visiting, $40,000). During FFY 2010, the MCH Program retained a consultant to assist with the conceptual development of an evidence-based home visiting model. As described elsewhere in this application, the Smart Start and Kids Kare programs are currently being merged into one program, "Smart Start," that will utilize the Healthy Families America model.

B. Budget

In addition to the salaries of 29.9 FTEs, associated other costs of employment (OEC) and indirect costs, a signficant portion of the unobligated funds from 2010 will be budgeted for several new initiatives. These initiatives will be implemented through contracts:

• Family Support Initiative -- Umbrella Organization
MCHB will continue relationship with the University of Delaware's Center for Disabilities Studies (CDS) who will direct the "umbrella organization" for family support services for children and youth with special health care needs (CYSHCN). CDS will address performance through the following systems level and targeted organizational level actions:
- Increase efficiency of the systems servicing children, youth and young adults with special health

care needs by reducing fragmentation and duplication and enhancing collaboration
- Care Coordination
- Capacity-building of organizations, parents, youth and young adults through assessment and coordinated training. Assessment of organizations within the umbrella should include, at a minimum, the following: Governance, Sustainability, Strategic Planning and Evaluation
- Provide information and referral services

$147,426

• Newborn Screening Program -- Long-Term Follow up
o Develop a plan and budget for a newborn screening (Metabolic and hearing) long-term follow up program

Development and Planning Process

Consultation and facilitation services for the purposes of developing infrastructure for long-term follow up program for the newborn screening program (e.g. assess community perceptions; facilitate consensus building forums; Assess existing state wide capacity etc)
$75/hr @ 200 professional hours $ 13,125

• Folic Acid Education Initiative
o Develop a plan and budget for a folic acid education initiative (i.e. social marketing campaign targeted to population using varied media outlets)

DPH is proposing the development of a Folic Acid Education Campaign and airing of televised public service announcements to increase awareness and education of the nutritional and health benefits of folic acid across the lifespan, and it's role in preventing birth defects of the brain and spine. The campaign will target low-income women of childbearing age in Delaware. Other media activities include mailings to food stamp recipients, local cable shows and advertising. Professional educational materials on folic acid will be distributed to DPH health clinics, Family Planning providers, WIC and Federally Qualified Health Centers.

- 1,427 televised public service announcement spots (30 seconds) on Comcast Spotlight
$19,998

• 3rd Annual Breast is Best Conference
o Improve maternity care practices as a strategy to improve breastfeeding
o At the end of the 3rd annual conference, participants will be able to:
? Describe ways to improve common hospital practices that can interfere with breastfeeding.
? Describe adverse effects that common caretaking practices have on the newborn.
? Identify successful breastfeeding interventions with the late preterm newborn.
? Discuss breastfeeding advocacy projects and programs.
? Discuss the current breastfeeding recommendations from the A. A. P.
$35,540

• Child Health Care Consultant -- Program Development and Design

Delaware seeks to expand the vision of building strong linkages between health and child care professionals, through a child care health consultant (CCHC) state-supported service delivery model. Supporting the health and safety of Delaware's children in child care settings is a key

mission of the ECCS program and the Title V program. Raising awareness through children's health promotion will increase access to health and developmental services. Implementing a state-supported service delivery model will allow for improved child outcomes in areas such as physical and mental health care, nutrition, environmental safety and injury prevention, asthma management, oral health care and developmental disabilities.

Revamping Delaware's Healthy Child Care America program, through the initiative, will strengthen Delaware's early childhood infrastructure. It will provide capacity to promote overall young child wellness and ensure school readiness. Child care health consultation promotes positive health behaviors, provides health education and anticipatory guidance to staff, children and parents. Also, it is beneficial in providing linkages within the system of care addressing mental health, nutrition, oral health and physical activity.
The Division of Public Health has partnered with Wesley College, Department of Nursing to provide the curriculum from the National Training Institute (NTI) of Child Health Consultants, University of North Carolina at Chapel Hill, NC. Wesley College is an authorized trainer of the NTI curriculum, a nationally approved training program. The OCCL will also be a key partner in this initiative.

A total of $172,000 has been allotted for contractual purposes to develop and implement the Child Care Nurse Consultant Training and Technical Assistance Program. DPH will release a Request for Proposal for full implementation of the program.

• Unintentional Injuries -- Childhood Injury Prevention Activities

According to the 2008 Delaware Childhood Injury report, the leading causes of injury hospitalizations for children ages 1-19 years in Delaware in the 2002-2005 period were falls at 25.1% (637 of 2,533 injuries), motor vehicle traffic-related injuries at 24.7% (626 of 2,533 injuries), and poisoning at 11.7% (295 of 2,533 injuries). For younger children, injuries are due to improper seat belt use, improper safety seat placement and riding in the front of a vehicle rather than the back. For teen drivers, injuries from crashes are attributed to speeding and inattentive driving and lack of seat belt use.

The Office of Emergency Medical Services in DPH has worked with partners to create a statewide Injury Prevention Coalition. The principal venue for collaboration in injury prevention in Delaware is the Delaware Injury Prevention Coalition (DIPC), facilitated by the Office of Emergency medical Services (OEMS), a sister agency. Although a majority of the coalitions work is related to adults, the infrastructure exists to add childhood injury as an essential component if additional resources are available. Multiple state and private organizations participate in DIPC, including De BMCH. Director, De BMCH is a member of the Motor Vehicle workgroup. De BMCH, as a part of its needs assessment, analyzed severity of motor vehicle crash-related injury data for children and youth who were treated at a hospital. This data was shared at a March meeting of the DIPC and the Office of Highway Safety (OHS) indicated their interest in working together. The two efforts to be undertaken this program year that will relate to the unintentional injury performance measure selected by De BMCH are:

In Sussex County, DeBMCH will, in partnership with OHS and others, conduct at least one child safety seat inspection/installation event in a community (not at an OHS-established station) setting, targeting Hispanic residents.

In Sussex County, DeBMCH will, in partnership with OHS and others, conduct at least one evening parent education session of teen drivers. OHS provides the speaker and De BMCH mobilizes partners and coordinates promotion of event.

As De BMCH does not have funding dedicated to Unintentional Injury Prevention as do other states, it is critical to focus on data driven priorities shared with sister agencies and develop community partnerships which will lead to long term relationships and opportunities to connect

with under-served populations. In this manner, De BMCH is building networks for future dissemination of prevention, risk-reduction and protective factor enhancement messages, resources and behavior change programs.

$8,000

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.